Medicaid in North Carolina
Annual Report
State Fiscal Year 2000

Division of Medical Assistance

Michael F. Easley
Governor

Carmen Hooker Buell
Secretary

Paul R. Perruzzi
Director

North Carolina
Department of Health and Human Services
Division of Medical Assistance
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Michael F. Easley, Governor
Carmen Hooker Buell, Secretary

Paul R. Perruzzi, Director

Dear Fellow North Carolinians:

I am pleased to present the Medicaid Annual Report for State Fiscal Year 1999 - 2000. This was a year of anticipation as the Division of Medical Assistance, along with the rest of the world, prepared for Y2K. Significant effort went into preparing for the rollover of 1999 into 2000, especially the development of contingency plans in case computer systems failed. Fortunately, the new millenium arrived uneventfully.

The Medicaid Program saw a year of increased expenditures after a major expansion in January 1999, adding coverage for the aged, blind and disabled who have incomes at or below 100% of the Federal Poverty Level. Changes in Medicaid funding of mental health services began to evolve after the mental health managed care program entitled "Carolina Alternatives" ended in March 1999 with a transition period through June 30, 1999.

Health Choice, a federal-state program of healthcare coverage for children in low-income families that do not qualify for Medicaid coverage, began operations in North Carolina in October 1998. Health Choice experienced its first full year of operation during State Fiscal Year 2000 in which it expanded to all 100 counties. Outreach associated with Health Choice resulted in some new eligibles for Medicaid, i.e. some children applying for Health Choice learned that they were actually eligible for Medicaid and then enrolled with the Medicaid Program. Efforts to simplify the application process for Health Choice were adopted by Medicaid so that it became much easier to apply for family coverage under Medicaid.

I invite you to read the full report to gain better insight into the Medicaid Program in North Carolina.

Sincerely,

Paul R. Perruzzi, Director

Division of Medical Assistance
Office of the Director
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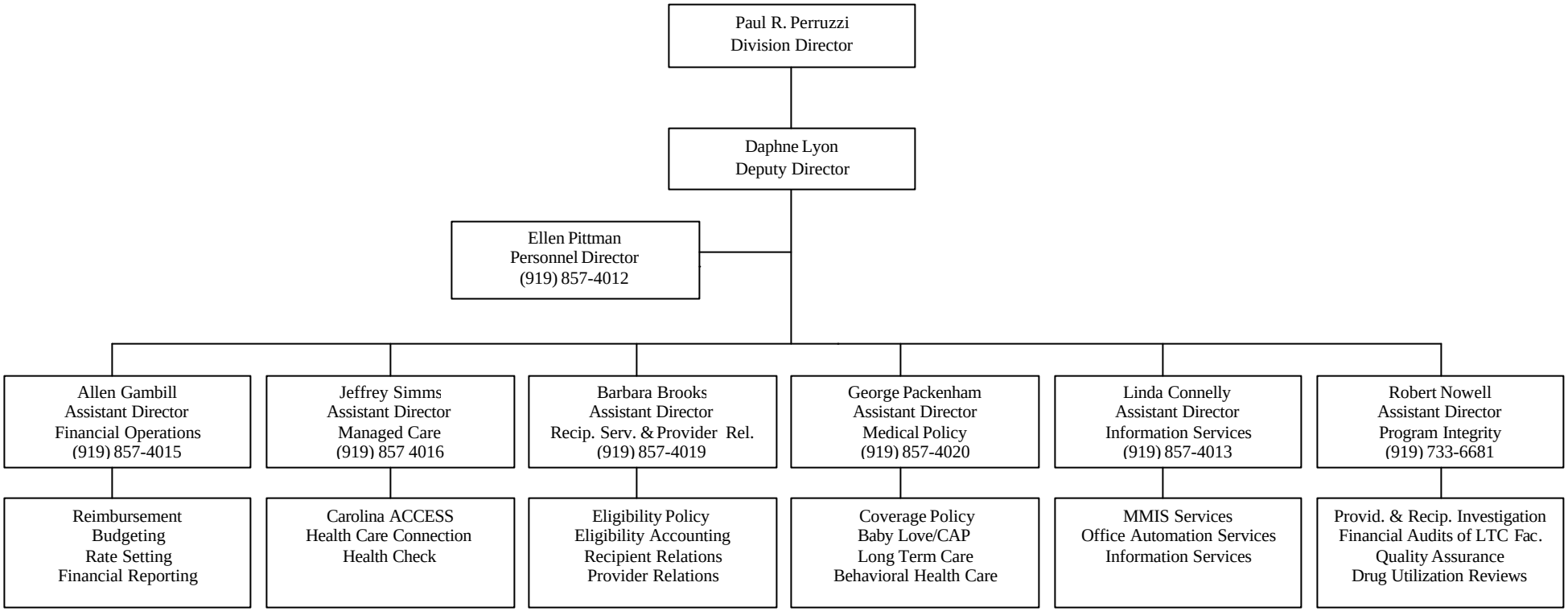

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State Fiscal Year 2000

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Medicaid Policy Changes in Brief

State Fiscal Year (SFY) 2000 brought successful new developments in North Carolina's Medicaid program, as well as continuation of efforts to improve the program's efficiency and cost-effectiveness while maintaining a high quality of service for Medicaid beneficiaries. Several policy changes supported the pursuit of these goals.

- Income limits increased so that elderly, blind, and disabled people with incomes that are at or below the federal poverty level and with limited assets are eligible for Medicaid. The change was effective January 1, 1999 and resulted in about 35,000 people becoming eligible for Medicaid.
- Medicaid physician reimbursement fees were changed to match Medicare rates. The change resulted in increases for most fees and should help improve Medicaid recipients' access to care.
- Definition of 'deprived child' was changed by eliminating the requirement that the caretaker relative not work more than 100 hours a month to be considered underemployed. This means the deprivation requirement has been entirely removed for eligibility of caretaker relatives and aligns Medicaid policy with Work First.
- Rules were changed to identify professionals who are allowed to give evidence that an individual is incompetent. Statements of lay persons (family and friends) can no longer be used to establish incompetence. A duration requirement was added requiring that the period of incompetence must be at least 30 days.
- Reimbursement methods for ICF/MR facilities were changed to allow payment for services equal to a predetermined rate which is the sum of the provider's direct and indirect costs plus an inflation factor.
- As a result of termination of the Carolina Alternatives waiver, Medicaid criteria for continuing stay in an acute inpatient psychiatric facility were revised and clarified.
- Disproportionate Share Hospital (DSH) payments continued to support hospitals that serve a disproportionate number of Medicare, Medicaid and indigent patients.

Medicaid Annual Report on the Internet

You can now access this report on the Internet. The text is under **Publications** and the tables are under **North Carolina Medicaid Statistics**. The address is:

http://www.dhhs.state.nc.us/dma/

Data Synopsis

Medicaid is an important source of healthcare for North Carolina's most vulnerable citizens. This includes aged, blind and disabled individuals, as well as pregnant women and low-income families who cannot afford to pay their healthcare expenses. Also, all children under the poverty level, and in some cases, above poverty level, are eligible for Medicaid in North Carolina.

As in past years, the largest proportion (75%) of Medicaid's service budget was spent for services to aged, blind and disabled individuals. The remainder, 25%, was spent on care for low-income families and children.

In SFY 2000, 25% of the service budget was spent on nursing facility care and on institutional care for persons with mental retardation. The State's fiscal year runs from July through June.

Total Medicaid and Medicaid-related expenditures increased to $5,789,133,085, a 17% increase over SFY 1999. The amount spent for program services was $4,796,682,219, an increase in service costs of 11% over SFY 1999. Table 12 on page 40 gives a detailed breakdown of these service expenditures.

A total of 1,221,266 people were eligible for Medicaid during SFY 2000. This was a 3.64% increase in total eligibles from SFY 1999.

During SFY 2000, a total of 1,200,906 people who were eligible for Medicaid were actually recipients. Recipients are eligibles who have used services. Total recipients increased 2% from State Fiscal Year 1999.

Martin County had the highest concentration of Medicaid eligibles in SFY 2000 with 350 people per 1,000 of county population on Medicaid. Orange County had the lowest concentration of Medicaid eligibles with 75 per 1,000 of county population on Medicaid.

Avery County had the highest Medicaid cost per eligible, which amounted to $5,695. Cumberland County had the lowest cost per eligible, $2,955. Statewide, the average cost per eligible was $3,809.

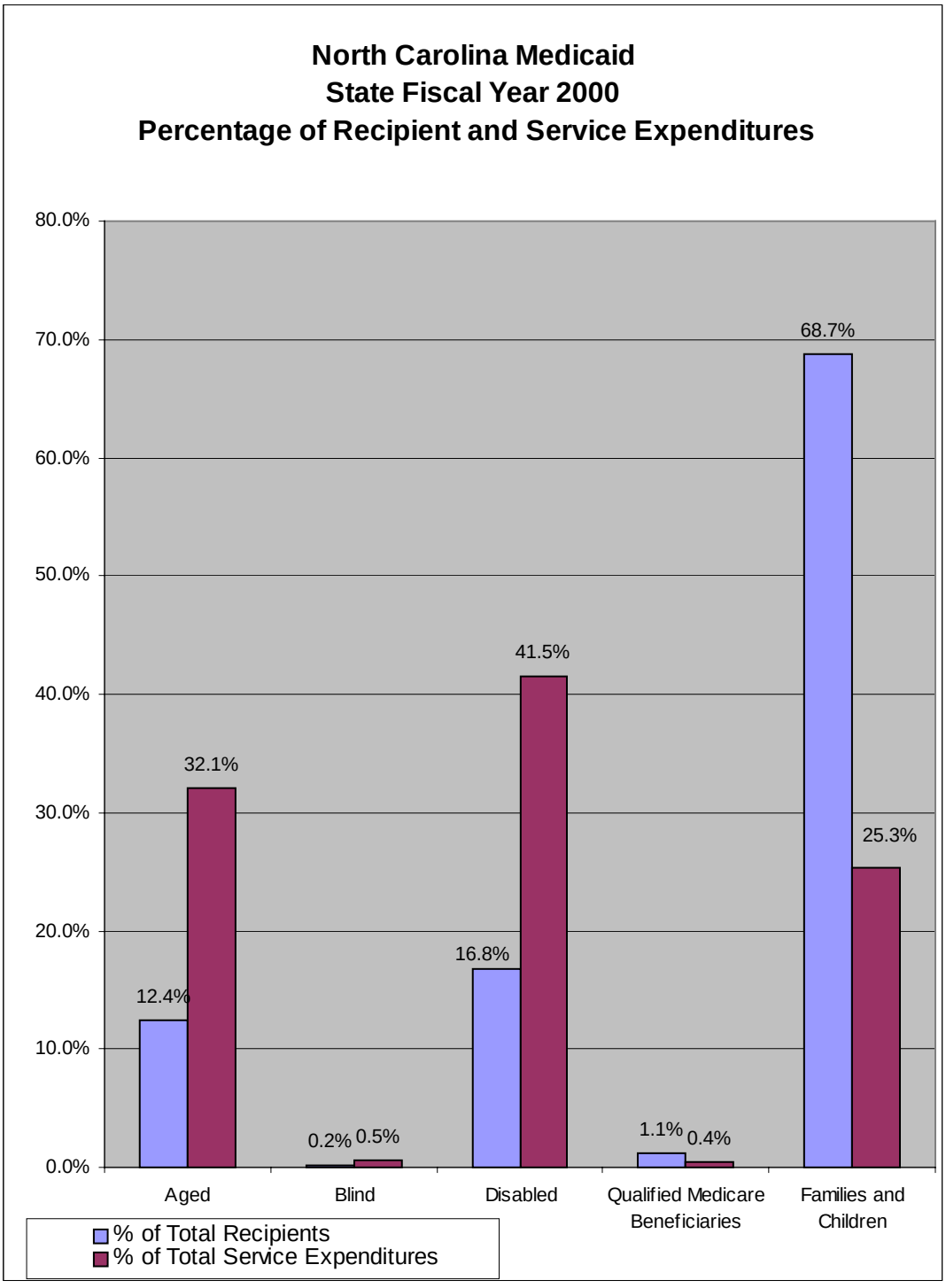
Prescription drug expenditures, at a level of $755 million, was the highest total cost of all Medicaid categories of service rendered for SFY 2000. Inpatient hospital expenditures, at $736 million, was the second highest service cost.

Carolina ACCESS is North Carolina's Medicaid managed care patient access and coordinated care program. All of the state's counties, with the exception of Mecklenburg County, participate in Carolina ACCESS. There were 563,552 clients enrolled in the program as of June 30, 2000.

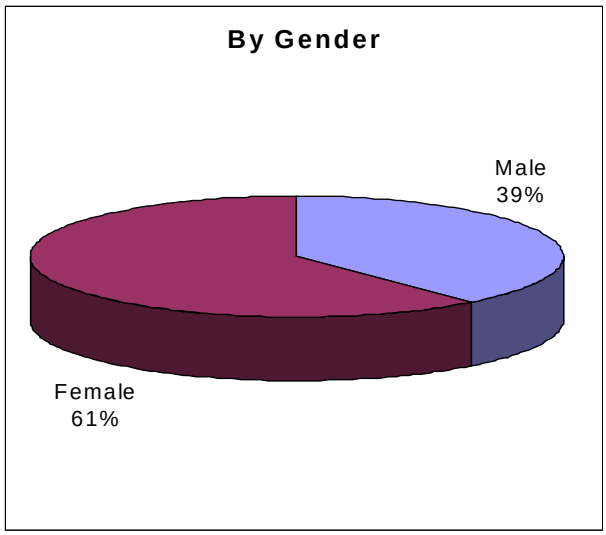
During Medicaid SFY 2000, the Division of Medical Assistance received almost $154,459,271 in rebates from pharmaceutical companies that contract with the State Medicaid program.

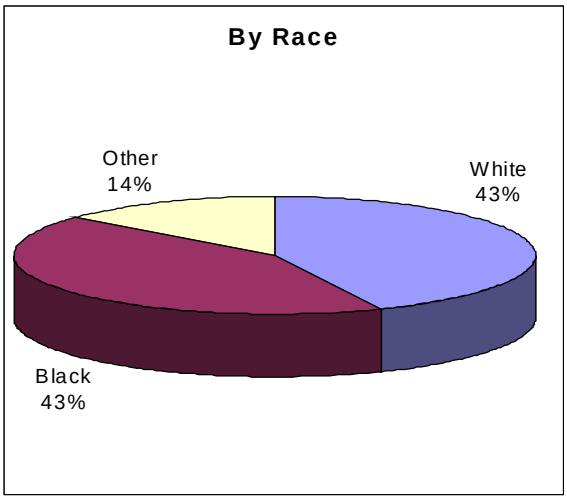
Medicaid Recipients

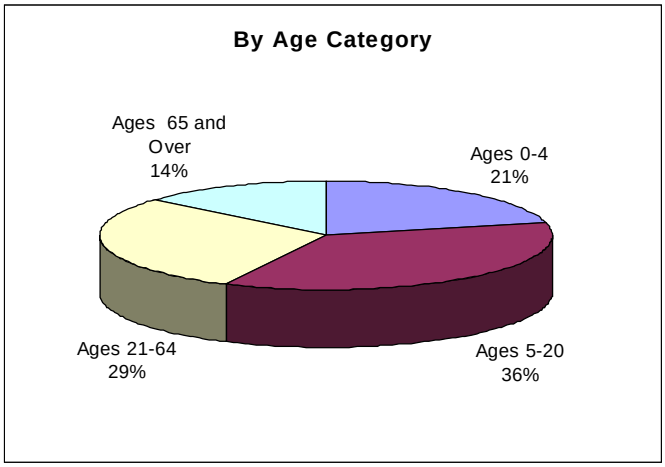
Of the major Medicaid eligibility categories, the AGED and DISABLED accounted for 75% of total expenditures, while families and children accounted for 25%. The AGED category, which accounts for 12.4% of the Medicaid recipients, used 32.1% of resources. The DISABLED, with 16.8% of total recipients, used 41.5% of Medicaid resources. See the charts on pages 3 and 4 for details.

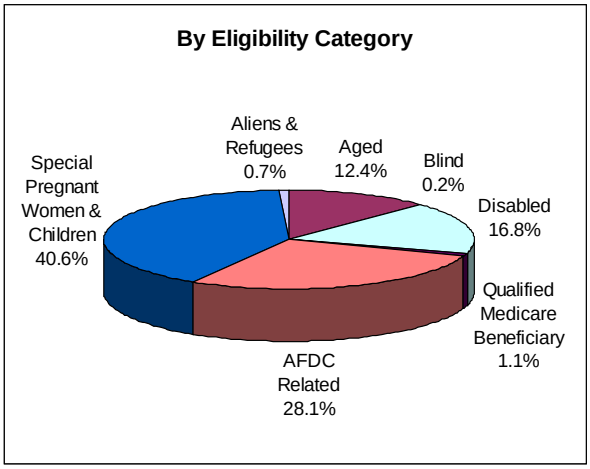

North Carolina Medicaid
State Fiscal Year 2000
Percentage of Recipient and Service Expenditures
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
12.4%
32.1%
0.2%
0.5%
16.8%
41.5%
1.1%
0.4%
68.7%
25.3%
Aged
Blind
Disabled
Qualified Medicare Beneficiaries
Families and Children
% of Total Recipients
% of Total Service Expenditures

Recipients of Medicaid Services









Medicaid Background/History

In North Carolina

History

Congress created the Medicaid program in 1965. It was designed as a medical safety net for two categories of low-income people receiving cash assistance:

- Mothers and children and
- Elderly, blind and disabled persons.

The federal and state governments jointly finance Medicaid. In North Carolina, the 100 counties also contribute to the non-federal share of costs. All states, the District of Columbia and some U.S. territories have Medicaid programs. Medicaid programs are governed by federal guidelines, but vary in eligibility criteria and covered services. In North Carolina, each county determines eligibility for Medicaid benefits based on policies established by the State.

North Carolina's program began in 1970 under the North Carolina Division of Social Services. A separate Division of Medical Assistance (DMA) was created within the Department of Human Resources in 1978. From 1978 to 2000, Medicaid expenditures grew from $307 million to $5.6 billion, and the number of people eligible for Medicaid increased from 456,000 to 1,221,266. During this time period, DMA staff increased from 121 to 334 people.

In over 20 years of operation, the programmatic complexity of Medicaid has paralleled the growth in both program expenditures and number of recipients. However, DMA has historically spent a relatively modest percentage of its budget on administration. In SFY 2000, the administration budget was 1.3% of total service dollars. This level of expenditure reflects Medicaid's use of efficient administrative methods and innovative cost control strategies.

Greatly overshadowing Medicaid in 1965 was the creation of Medicare, a federally operated health insurance program for elderly, blind and disabled individuals, regardless of income. Composed of two separate programs (Part A and Part B), Medicare is financed through Social Security payroll taxes, beneficiary premiums and general revenues.

Many low-income persons qualify for both Medicare and Medicaid. Generally, Medicare covers acute care needs, subject to certain benefit limitations. For individuals who qualify for both Medicaid and Medicare, Medicaid pays Medicare cost-sharing amounts and fills in many gaps in Medicare's benefit package, especially in the area of long-term care services and prescription drugs.

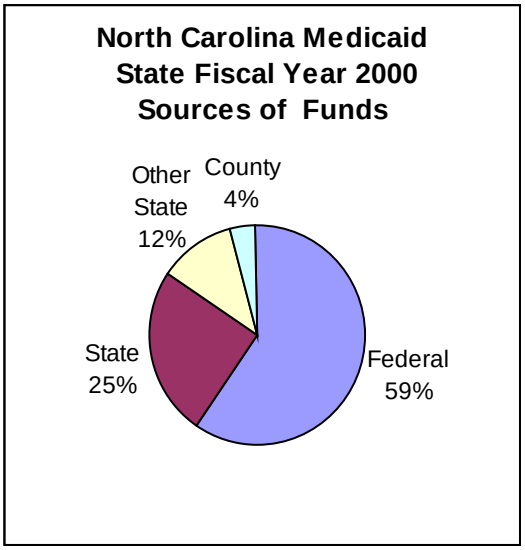
Federal Financial Participation

The Federal Government pays the largest share of Medicaid costs. Federal matching rates for services are established by the Health Care Financing Administration (HCFA). HCFA uses the most recent three-year average per capita income for each state and the national per capita income in establishing this rate. As North Carolina’s per capita income rises, the federal match for Medicaid declines, requiring the State and counties to increase their proportionate share of Medicaid costs.

The established federal matching rates for services are applicable to the federal fiscal year (FFY), which extends from October 1 to September 30. The State's fiscal year (SFY) runs from July through June. Because the federal and state fiscal years do not coincide, different federal service matching rates may apply for each part of the overlapped state fiscal year. The federal match rate for administrative costs does not change from year to year. Table 1 in APPENDIX A shows the federal matching rates that apply for State Fiscal Year 2000.

Funding Formula

The federal matching rate for Medicaid services varies from state to state based on per capita income. Nationwide in SFY 2000, the federal match rate varied from a low of 50 percent to a high of 77 percent. Additionally, states may require localities to participate in the non-federal share of expenditures. In North Carolina, each county contributes 15 percent of the non-federal share. During SFY 2000, the federal, state and county shares of total expenditures were approximately 59 percent, 37 percent, and 4 percent, respectively. See Table 6 in Appendix A for a detailed breakdown of these shares.



Eligibility

As of June 30, 1999, the average monthly number of people in North Carolina eligible for Medicaid was 818,136. That figure increased to 850,811 for SFY 2000. See the chart on the following page for more details.

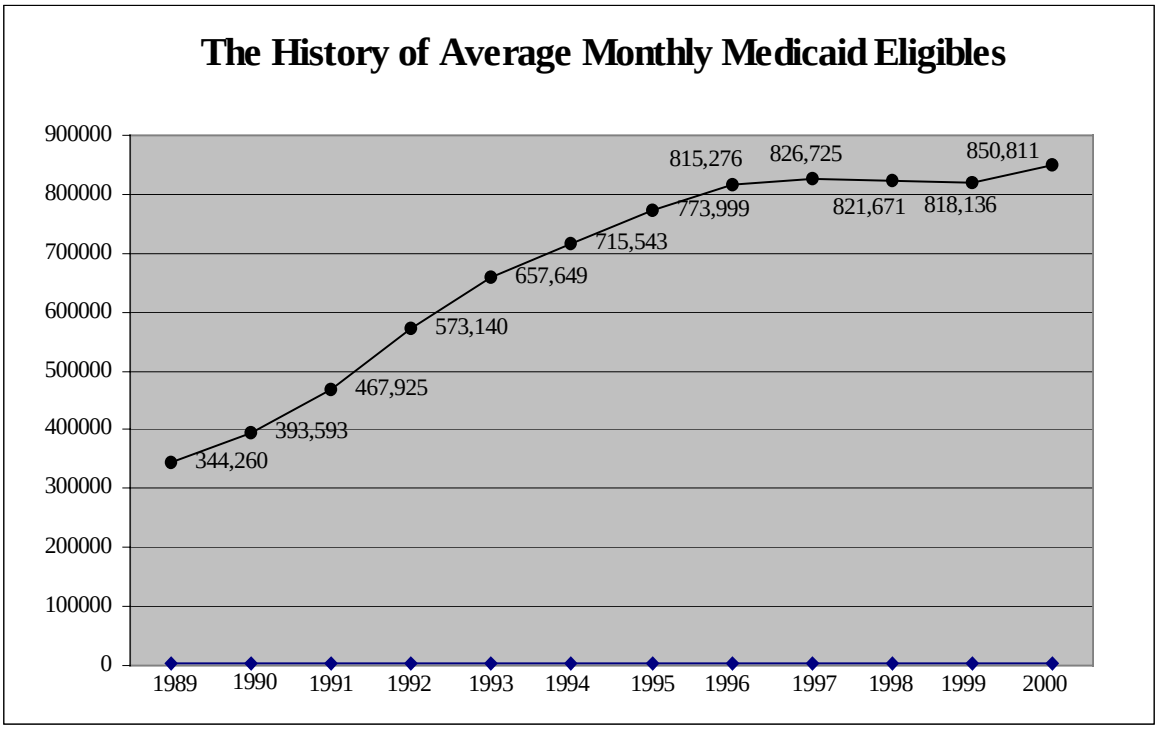
Medicaid benefits are available for certain categories of people specified by law and are based on specific financial (income and resources) criteria. North Carolina's Medicaid program has two main components, a **Categorically Needy** program and a **Medically Needy** program.

Categorically Needy - The categorically needy group consists of people who receive or are eligible to receive cash assistance payments under other governmental assistance programs or who are specially authorized by law to receive benefits. These include:

- Recipients of Work First Family Assistance, formerly AFDC, foster care and adoption assistance (Title IV-E) payments, SSI (Supplemental Security Income) payments, State and County Special Assistance payments, or supplemental assistance programs to visually handicapped individuals.
- Pregnant women
- Infants and children up to age 19
- Persons aged 65 and above or persons who are blind or disabled (as defined by the federal Social Security Administration criteria) who qualify for Medicare Part A and have income and assets below federal standards.

For the aged, blind and disabled, federal regulations permit states either to accept as categorically needy all persons found eligible for the federal Supplemental Security Income (SSI) program or to set categorically needy eligibility criteria that are more restrictive than SSI standards.

Until January 1, 1995, North Carolina elected the latter approach, making it one of 13 "209(b)" states, so-named for the statutory citation explaining the option. What this means is that SSI recipients have to make a separate application to North Carolina's Medicaid program and meet more stringent financial means tests to



become eligible for coverage. Beginning January 1, 1995, North Carolina SSI recipients automatically qualified for Medicaid benefits.

Medicaid's Medicare-Aid program pays for out of pocket expenses for Medicare-covered services, such as premiums, deductibles and coinsurance for those who qualify. The income and resource limits that must be met to qualify for Medicare-Aid are higher than that necessary to receive full Medicaid coverage.

Medically Needy – The medically needy have the same general eligibility criteria as the categorically needy, however they do not receive cash assistance payments generally because their income is higher than state standards allow. If the income of the medically needy individual is higher than the allowable level, he or she must incur medical expenses equal to the excess income before becoming Medicaid eligible.

This criterion for eligibility is known as the Medicaid deductible or the Medicaid "spend down." Ironically, these people must "spend down" to levels lower than most eligibility requirements, i.e. to 133% of the AFDC payment level (not to the other current income levels such as the poverty level or the SSI payment level).

How the Program Works

Medicaid operates as a vendor provider payment program. Eligible families and individuals are issued a Medicaid identification card each month. Program eligibles may receive medical care from any of the 59,289 providers who are currently enrolled in the program. Providers then bill Medicaid for their services. Table 4 in Appendix A shows the broad range of provider types that Medicaid enrolls.

Medicaid provides funding for health care for many people who otherwise would not be able to afford care. Medicaid is also an ongoing source of both State and federal revenues for North Carolina's healthcare providers, including many public providers such as state hospitals and local health departments.

Administrative Contracts

Certain functions of the Medicaid program are performed for DMA under contract. Some of these include:

EDS Corporation -- DMA contracts with EDS to perform many of Medicaid's administrative functions. Currently, EDS pays claims, serves as a focal point for provider questions and problems, trains new providers, operates the prior approval system for most Medicaid services and operates the North Carolina Medicaid Management Information System (MMIS Plus).

During 1989, the contract for claims processing services was competitively bid as required by federal law. EDS won the right to continue operating as DMA's fiscal agent for the next four years, plus the potential for four one-year extensions. Since that time, all extension options were exercised and an additional year was negotiated. The contract has been extended through June 30, 2004 to allow for implementation of HIPAA standards prior to rebid.

Medical Review of North Carolina (MRNC) -- MRNC conducts quality assurance reviews of the Community Alternatives Programs (CAP), nursing facilities and the Health Maintenance Organization contracts. See Program Integrity Section on page 10 for additional reviews conducted by MRNC.

First Health (FH) -- DMA contracts with First Health to conduct pre-admission certification and concurrent reviews of inpatient psychiatric services for children under age 21 and adults. First Health conducts pre-admission and concurrent reviews in Psychiatric Residential Treatment Facility (PRTF'S). These reviews assure that admissions and lengths of stay are medically necessary and appropriate for this population.

First Health Services Corporation (FHSC) – DMA contracts with FHSC to perform certain components of the retrospective Drug Use Review (DUR) Program. FHSC generates quarterly recipient and provider profiles from the paid claims computer tapes in accordance with the DUR Board's criteria.

FHSC has a therapeutic criteria catalog that the DUR Board can use as is, amend, or make additions. The DUR Board can also elect to create new criteria that FHSC must be able to implement and run. The interventions and responses resulting from the review of these profiles are tracked by FHSC's software. FHSC must provide the statistics and cost saving data for the DUR Annual Report to HCFA. In addition, FHSC provides ad hoc reporting for retrospective DUR projects, studies and reviews.

Optical Contracts - Medicaid contracts with the N.C. Department of Correction's Correctional Enterprises to provide eyeglasses at predetermined rates. In most cases, providers of Medicaid eye care services must obtain eyeglasses through this organization.

Audit Contracts - The DMA Audit Section has contracts with two certified public accountants to conduct on-site compliance audits of nursing facilities (NF's) and intermediate care facilities for the mentally retarded (ICF-MR) who are enrolled in the Medicaid program. These audits supplement DMA's in-house audit activities and verify the accuracy of the providers' cost reports.

In addition, DMA contracts with Blue Cross/Blue Shield of Tennessee to perform Medicaid settlement activities for rural health clinics and with BCBS of North Carolina to perform Medicaid settlement activities for hospitals and State-operated NF's and ICF-MR's.

Cooperative Arrangements

Although DMA administers Medicaid, other agencies, DHHS divisions, and State departments work closely with the program and perform important functions.

Counties - The Department of Social Services in each of North Carolina's 100 counties have the central role in determining Medicaid eligibility for their residents. In addition, counties contribute approximately 5 percent of the cost of services for Medicaid patients.

Division of Social Services (DSS) -- The DSS conducts Medicaid recipient appeals when the person making the application contests eligibility denials. A disability determination unit of the State's Division of Vocational Rehabilitation determines whether an individual is eligible for Medicaid based on disability. This unit also makes disability determinations for two federal programs under a contract with the Social Security Administration including Title II - Social Security benefits and Title XVI - Supplemental Security Income.

Division of Mental Health/ Developmental Disabilities/ Substance Abuse Services (DMH/DD/SAS) -- DMA works closely with the DMH/DD/SAS to plan for and monitor community mental health services. Many services provided by the mental health authorities are covered by Medicaid. During SFY 1999, DMA and DMH/DD/SAS operated the Carolina Alternatives Program, a pre-paid capitation plan in which DMA paid a monthly capitation fee to DMH/DD/SAS for mental health and substance abuse services of Medicaid eligible children. This program ended June 30, 1999 returning to a fee for services Medicaid plan. DMA and DMH/DD/SAS also work cooperatively to operate the Community Alternatives Program for persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD). This program is a valuable resource for providing community-based services as a cost-effective alternative to institutional care in an ICF-MR.

Division of Public Health- DMA and the Division of Public Health cooperate in a number of efforts to improve care for people with HIV and AIDS. The AIDS Care Unit in the Division operates HIV Case Management Services (HIV/CMS) and the Community Alternatives Programs for Persons with AIDS (CAP/AIDS) for DMA.

Division of Public Health, Women and Children's Health Section (WCH), -- WCH, within the Department of Health and Human Services (DHHS), operates a variety of healthcare programs. Medicaid pays for many of the services that are offered through WCH. WCH and local health departments also play a central role in the operation of Baby Love, a care coordination program designed to assure appropriate medical care for pregnant women, and the Health Check Program which provides preventive and other health care services for children. Both programs are discussed in more detail in the "Special Programs" section of this report.

Division of Aging (DOA) -- DMA and DOA staff work together on many issues that are important to the aged population. Jointly, DMA and DOA design a long-range plan of services for the elderly in North Carolina. In particular, DMA staff routinely participate in policy development projects on housing and in-home aide services.

Division of Facility Services (DFS) -- DFS has the responsibility for certifying and monitoring facilities in North Carolina. DFS ensures that all patients, including those covered by Medicaid,

receive quality care if they reside in a facility.

Department of Public Instruction (DPI) -- The Individuals with Disabilities Education Act (IDEA) is the federal law requiring education-related services to be provided to pre-school and school aged children with physically and mentally challenging conditions. DMA works with DPI to provide Medicaid funding for those related services that are medically indicated, such as speech, physical and occupational therapies.

Covered Services

North Carolina Medicaid covers a comprehensive array of services to treat eligible enrollees when they become ill. Preventive services include annual physicals for adults and child health screenings provided under the Health Check program. Although North Carolina's program is called Health Check, many providers are accustomed to referring to it by its federal name, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Additional details are discussed in the "Medicaid In Depth" section of this report.

Medicaid imposes certain standard limitations on services including a limit of 24 visits to practitioners, clinics and outpatient departments and a limit of six prescriptions per month. There are exceptions to these limits for preventive care to pregnant women, children eligible for Health Check, people with life threatening conditions, participants in the Community Alternatives Programs (CAP) and other selected groups. Table 5 in Appendix A lists Medicaid services for SFY 2000.

Some services require nominal co-payments and others require prior approval. Both requirements ensure that care received is medically necessary. Service limitations and co-payment requirements are discussed in more detail in the "Medicaid In Depth" section of this document.

Rate Setting

Prospective payment rates and fee schedules are very important in controlling Medicaid program costs. Taking into account the level of funding provided by the North Carolina General Assembly, payment rates are established according to federal and State laws and regulations. DMA reviews, monitors and adjusts fee schedule amounts. See "Medicaid in Depth" for more information about the payment mechanism that is applicable to each type of service.

Program Integrity

DMA’s program integrity efforts are designed to promote program efficiency and effectiveness. The following are some of the specific efforts toward that goal.

Medicaid Eligibility Error Rate Reduction -- The Quality Assurance (QA) Section of DMA has the responsibility of monitoring the accuracy rate of eligibility determinations made by the Department of Social Services in each of North Carolina’s 100 counties. The QA staff conducts both federally mandated quality control reviews and State-designed targeted reviews. This review process looks at both active and denied cases. Corrective actions are taken whenever appropriate. Error trends, error-prone cases and other important error reduction information are communicated quickly to eligibility staff. Eligibility supervisors then conduct evaluations and training and make the necessary adjustments to eliminate errors and to prevent future mistakes.

North Carolina has never been penalized for exceeding the three-percent federal tolerance level for payment error rates. North Carolina's low payment error rate is the result of the partnership between DMA and North Carolina's counties.

Recovery of Overpayments -- DMA Program Integrity efforts include:

- Identifying providers and recipients who abuse or defraud the Medicaid program
- Identifying and recovering provider and recipient overpayments
- Educating providers or recipients when errors or abuse are detected
- Protecting recipients' rights
- Evaluating the medical claims processing procedures for accuracy and improvement.

Four investigative units of the Program Integrity Section refer cases of suspected fraud or abuse to the Medicaid Investigations Unit of the Office of the Attorney General. The Quality Assurance Unit supports the recipient fraud staff in each of the county departments of social services to handle those county investigations. A summary of Section activities follows:

State Fiscal Year 2000	
Provider Activities:	
Investigations Opened	**1732**
Cases with Overpayment	**1193**
Dollars Collected	**$4,443,083**
County DSS Recipient Investigations:	
Cases Opened in SFY 2000	**1951**
Dollars Collected	**$1,255,046**
Healthcare Facility Audit Activities:	
Audits	**593**
Dollars Collected	**$10,784,802**
Total Collected	**$16,482,931**

These amounts do not include loss avoidance from interventions or improvements made to policy or claims payment processes.

The Surveillance and Utilization Review Subsystem (S/URS) of the Medicaid Management Information System identifies providers and recipients whose patterns of practice and use of services fall outside of the norm for their peer group.

Utilization Control and Review -- The Division of Medical Assistance operates several other programs directly or under contract to make sure that Medicaid funds are spent appropriately. These programs are designed to prevent and recover incorrect payments. Prior approval and prior authorization for services ensure that planned care is appropriate for the Medicaid client's needs. EDS operates the prior approval system for most services.

DMA also has contracted with MRNC to evaluate DRG coding to identify improper reimbursement maximization and other potentially fraudulent billing practices. First Mental Health is under contract to conduct pre-admission, concurrent and post-payment reviews of inpatient psychiatric admissions for children under 21. In addition, paid claims are reviewed periodically and those that differ significantly from established norms are analyzed to determine whether the services are medically necessary and appropriate.

Third Party Recovery (TPR) -- Medicaid is, by law, the payer of last resort. As a condition of receiving Medicaid benefits, recipients agree to allow Medicaid to seek payment from available third party health care resources on their behalf. All other third party resources must be used before Medicaid dollars are spent. These resources, such as health and casualty insurance and Medicare, are important means of

keeping Medicaid costs as low as possible.

In SFY 2000, insurance coverage and refunds from a variety of sources were all increased over the prior year resulting in reduced Medicaid expenditures. For example, when a person is eligible for both Medicare and Medicaid, the primary payer is Medicare. This cost avoidance policy saved our Medicaid program $937,272,541, a 9% increase over last year.

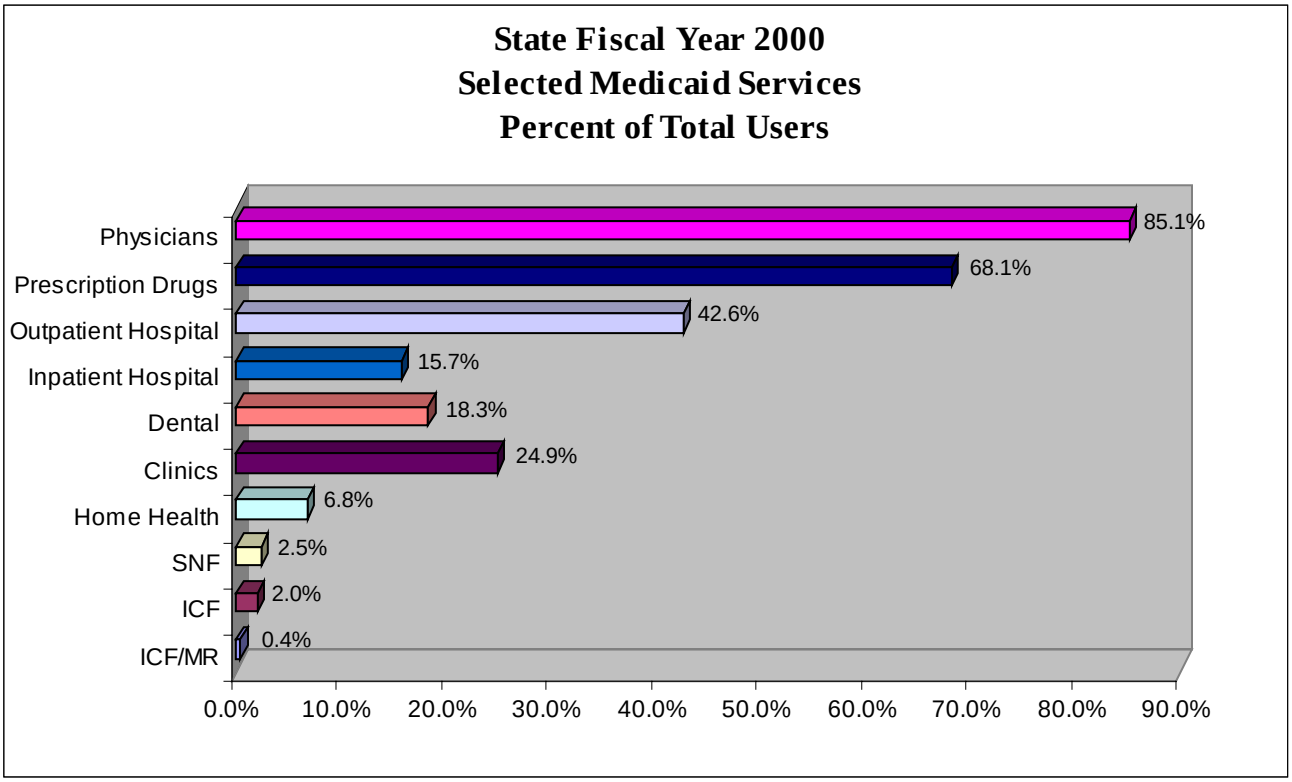
TPR also implements cost avoidance procedures that identify private health insurance plans that provide medical coverage to North Carolina Medicaid recipients. These insurance carriers paid $158,002,122 (a 56% increase over last year) on behalf of Medicaid patients. Additionally, claims totaling $111,704,144 (a 10% increase over last year) were returned to providers with instructions to file with other insurance carriers.

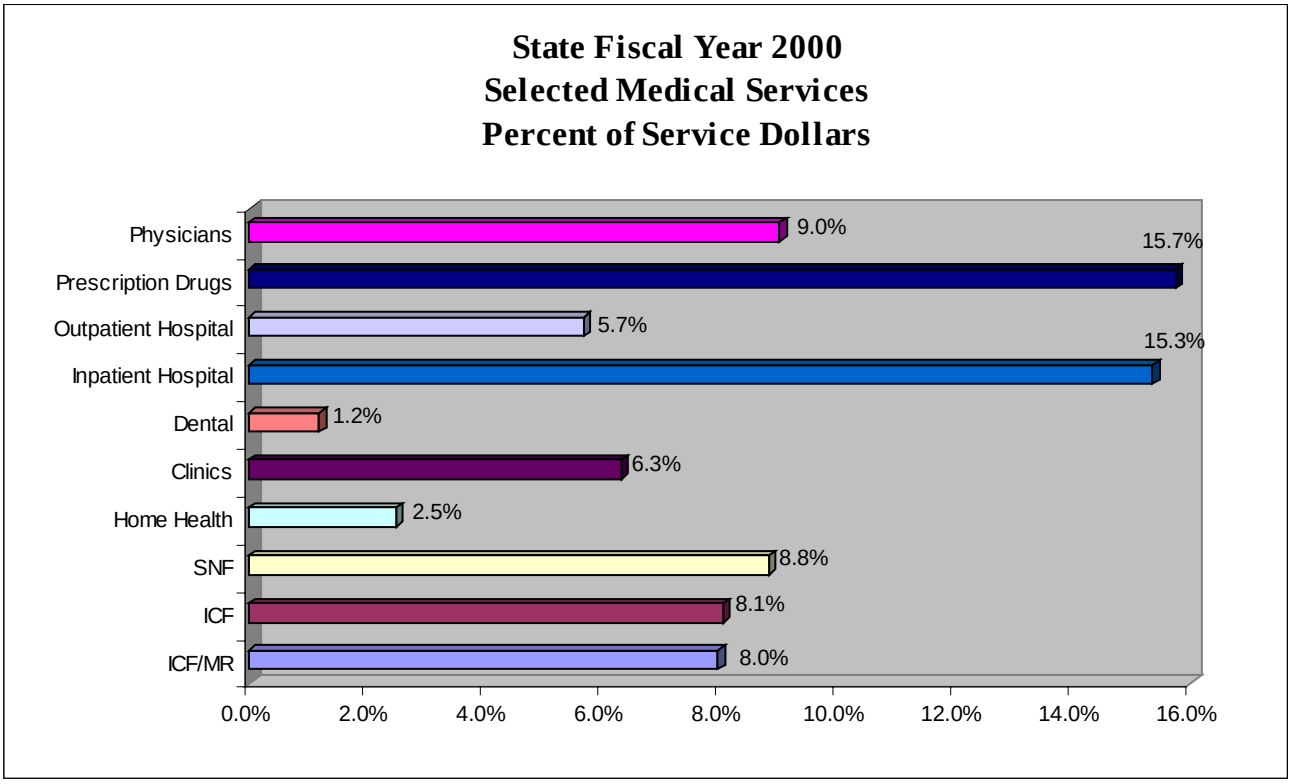
North Carolina's Medicaid agency continues to receive national recognition for its efforts in recovering third party payments. During SFY 2000, TPR significantly increased recoveries from the following sources (Note: TPR recovered $16,574,881 more dollars in SFY 2000 than in the prior year, an increase of 69%, resulting primarily from increased productivity of staff and contractors, investment in automation and improved utilization of computer software capabilities.):

TPR RECOVERY COMPARISON

SFY 1999 vs. SFY 2000

Source of Recovery:	SFY 2000	SFY 1999	% Increase
Medicare	$4,059,383	$2,408,384	69%
Health Insurance	$24,689,113	$10,637,066	132%
Casualty Insurance	$9,656,402	$9,179,130	5%
Absent Parent	$432,827	$369,006	17%
Estate Recovery	$1,690,240	$1,359,498	24%
Totals	**$40,527,965**	**$23,953,084**	**69%**


State Fiscal Year 2000
Selected Medicaid Services
Percent of Total Users
Physicians
Prescription Drugs
Outpatient Hospital
Inpatient Hospital
Dental
Clinics
Home Health
SNF
ICF
ICF/MR
85.1%
68.1%
42.6%
15.7%
18.3%
24.9%
6.8%
2.5%
2.0%
0.4%
0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0% 80.0% 90.0%


State Fiscal Year 2000
Selected Medical Services
Percent of Service Dollars
Physicians
Prescription Drugs
Outpatient Hospital
Inpatient Hospital
Dental
Clinics
Home Health
SNF
ICF
ICF/MR
9.0%
15.7%
5.7%
15.3%
1.2%
6.3%
2.5%
8.8%
8.1%
8.0%
0.0% 2.0% 4.0% 6.0% 8.0% 10.0% 12.0% 14.0% 16.0%

Medicaid in Depth

Medicaid offers a comprehensive array of services for program eligibles. Federal law requires coverage of some services, but States can elect to cover other service options. All services must be determined to be medically necessary in order for Medicaid to pay for them.

Th following is a list of services that require a co-payment and the amount of the co-payment:

STATE FISCAL YEAR 2000
Medicaid Copayment Amounts

SERVICE	CO-PAYMENT
Chiropractor Visit	$1.00
Dental Visit	$3.00
Optical Service	$2.00
Optometrist Visit	$2.00
Outpatient Visit	$3.00
Physician Visit	$3.00
Podiatrist Visit	$1.00
Prescription Drug (Including Refills)	$1.00

Co-payment amounts do not apply to the following services:

- Family planning services
- Services to pregnant women
- Community Alternatives Program services
- Services to children under age 21
- Services for nursing facility residents
- Mental hospital patients
- Hospital emergency room services
- Any services to Community Alternatives Program (CAP) participants
- Rural health clinic services
- Non-hospital dialysis treatments
- State-owned mental health facility coverage
- Services covered by both Medicare and Medicaid
- Services to enrollees of prepaid plans

Mandatory Services

At a minimum, all state Medicaid programs must cover a core set of health services. The following mandatory services are provided for Medicaid recipients in North Carolina:

Inpatient Hospital Services --
Medicaid covers hospital inpatient services, based on medical necessity, without a limitation on the length of stay. Special restrictions apply to abortions, hysterectomies and sterilization. Hospital services are paid on the basis of diagnosis related groupings (DRG' s).

Hospital Outpatient Services --
Outpatient services are covered subject to a limitation of twenty-four medical visits annually. This limitation does not apply to emergency room visits, which have no limits. A $3.00 per visit co-payment applies except for certain exempt groups and services. Hospital outpatient services are paid to the provider at 80 percent of actual operating costs.

Other Laboratory and X-ray --
Laboratory and x-ray services are covered when ordered by a physician. These services are covered in a variety of settings. Payment for these services is based on a statewide fee schedule.

Nursing Facility Services -- Nursing Facility (NF) services are federally mandated and covered for Medicaid recipient's aged 21 and older in need of NF level of care. The State also has chosen a federal option to cover NF services for people under age 21. Prospective patients must be pre-certified by a physician in order to

receive nursing facility care. Nursing facility services are paid on a prospective per diem rate.

Physician Services -- Physician services are covered subject to an annual 24-visit limit. Selected surgical procedures require prior approval. A $3.00 co-payment is required on physician services except for certain exempt groups. Payment is made based on the physician's actual charge or the statewide Medicaid fee schedule amount, whichever is less. Medicaid uses the American Medical Association's Current Procedural Terminology (CPT) coding structure as a basis for physician service reimbursement.

Home Health Services -- Medicaid covers visits provided by certified home health agencies for skilled nursing services, physical therapy, speech-language pathology services and home health aide services for patients needing such care in their homes. Under Home Health, Medicaid also pays for medical supplies for these patients. Home Health agencies are paid the lower of their customary charge to the general public or a maximum per visit rate established by DMA for each type of service.

Health Check Services -- The Health Check program (referred to as EPSDT in federal regulations) provides child health screening checks and necessary diagnosis/treatment. Also, referral for treatment of health problems detected during the screening of a Medicaid recipient 20 years of age or younger is offered. Health Check services do not count toward the annual 24-visit limitation and no co-payment is required. Private providers, county Health Departments and Community, Rural, Migrant and Indian Health Centers all participate as Health Check providers. For a complete description of this program, see Health Check Program on page 19 under “Special Programs”.

Family Planning Services -- Medicaid covers family planning consultation, examination and treatment prescribed by a physician. Sterilization and abortions are permitted under limited circumstances and require special documentation and approval. Payment is made based on the type of provider furnishing the particular service.

Federally Qualified Health Centers and Rural Health Centers -- Certain clinics that meet federal requirements are designated as Federally Qualified Health Centers (FQHC's) or Rural Health Centers (RHC's). Services provided by these facilities are not subject to co-payments. FQHC's and RHC's are reimbursed their reasonable costs as required by federal law.

Durable Medical Equipment -- Durable medical equipment suitable for use in the home is reimbursed via a fee schedule.

Nurse Midwife and Nurse Practitioner Services -- Nurse midwives practicing in accordance with state law are reimbursed at the same rates as physicians for those services which they are authorized to perform.

Medical Transportation -- Federal regulations require coverage of transportation to medically necessary covered services. The NC Medicaid Program meets this requirement by:

1. Medically necessary ambulance transportation is covered.
2. County departments of social services establish a local transportation network, which may range from providing bus tokens to using county employees in county owned vehicles to transport Medicaid recipients. These county transportation costs may be billed as a benefit cost or as an administrative cost, depending upon service delivery. Federal and State funds are

then used to match the county expenditure. See Table 1 in Appendix A for all of the matching ratios.

3. Residents of nursing facilities and adult care facilities receive transportation (other than medically necessary ambulance services) from the facilities in which they reside. Medicaid makes a per diem payment to the facility on behalf of each Medicaid eligible resident in order to reimburse the nursing facilities for these transportation costs.

Optional Services

Federal law permits States to cover additional services at their option. Where these services are categorized as "optional", they must be provided to all children under age 21 when the medical necessity of such services are confirmed through a Health Check screening. The following are optional services North Carolina Medicaid covers:

Intermediate Care Facilities for the Mentally Retarded (ICF-MR) -- Services in ICF's-MR are covered for those who are mentally retarded or who have a related condition. ICF-MR facilities must meet certification requirements relating to provision of habilitation services and basic intermediate care services. Intermediate care facilities for the mentally retarded are paid prospective per diem rates.

Personal Care Services in Private Residences -- Medicaid Personal Care Services (PCS) cover in-home aide services in a private residence that perform personal care tasks for the patient who, due to a medical condition, needs help with such activities as bathing, toileting, moving about, and keeping track of vital health signs. The services may only be performed in the patient's residence. While in the patient's home, the aide may also perform essential home management and housekeeping tasks for the patient, though secondary to the personal care tasks necessary for maintaining the person's health. The care is provided according to a plan of care developed by a registered nurse and authorized by the patient's physician.

Medicaid payment is available up to the number of hours authorized on the plan of care, not to exceed 80 hours per month. PCS is provided by licensed home care agencies enrolled with DMA. The agency is paid the lesser of the agency's usual customary charge and the Medicaid maximum allowable rate.

Please see page 22 for a review of personal care services in adult care homes.

Prescription Drugs -- Medicaid covers most prescription drugs for all recipients and insulin for diabetic patients. Drug coverage is limited to six prescriptions per month unless it is shown that additional medication is needed for treatment of a life-threatening illness or disease. Recipients may use only one pharmacist per month, except in the case of an emergency. A $1.00 per prescription co-payment applies, except for certain exempt groups. Payment for drugs is based on the average wholesale price less 10% plus a $5.60 dispensing fee or the usual/customary charge to the public, whichever is less.

Dental Services -- Most routine dental services are covered, such as exams, cleanings, fillings, x-rays and dentures. Additional preventative services are covered for children eligible under the Health Check Program. Prior approval is required for some dental services. A per visit co-payment of $3.00 applies for all recipients, except for exempt groups. Payment is made on the basis of a statewide fee schedule.

Eye Care Services -- Medicaid covers medical eye examinations, corrective eyeglasses, medically necessary contact lenses and other visual aids. Prior approval is required for all visual aids and various optical services/exams. There are limitations regarding the frequency of doctor visits and the number of dispensed visual aids during specific eligibility periods. A $3.00 co-payment is applicable to opthamologist visits, while a $2.00 co-payment applies to optometrist visits. Although a $2.00 co-payment is generally required for new eyeglasses, eyeglass repairs and contact lenses, there are some exemptions.

Through a contractual agreement, Medicaid eyeglasses are supplied through the North Carolina Department of Correction's Nash Optical Plant, located in Nashville, North Carolina. Providers must obtain Medicaid eyeglasses through this laboratory unless, due to extenuating circumstances, prior approval is granted.

Hearing Aid Services -- Single and binaural hearing aids are covered once every four years for Medicaid recipients under 21 years of age. FM systems are covered for preschool children ages 4 and above. An ENT specialist, otologist or otolaryngologist must submit a prior approval request, accompanied by an audiological report documenting the medical necessity of the hearing aid(s). Exceptional requests for replacement or new aids due either to breakage that is not covered by manufacturer warranty, loss of aid or recipient growth also require prior approval. There are no co-payments for hearing aid/hearing aid services.

Mental Health Services -- Patients that have a plan of treatment developed by and on file with an Area Mental Health Program, are offered outpatient mental health services, partial hospitalization and emergency services through Area Programs. Visits do not count against the annual 24-visit outpatient limit. Area Program Centers are paid a negotiated service rate.

Additionally, visits to independent psychiatrists, physicians and to Ph.D and MA psychologists employed and supervised by a physician are covered for mental health services. Prior approval is required for outpatient visits following the first two visits. Private practice psychiatrist visits count against the annual 24-visit outpatient limit and a co-payment applies when applicable.

Payment is made on a fee schedule basis for outpatient visits. Inpatient State and private mental health hospital services are covered for recipients over age 64 or under age 21. Payments to psychiatric hospitals are based on each hospital's actual allowable and reasonable costs.

Adult Health Screening Program-- The Adult Health Screening Program is not a mandatory service but complements the Health Check program for people age 21 and older. The program covers a comprehensive annual health assessment for the Medicaid client with the expectation that the health screening will prevent a serious illness through early detection and treatment of illnesses. Certain components of a health assessment must be included to qualify for payment. The screening applies toward the annual 24-visit outpatient limit and a $3.00 co-payment applies. Payment is based on the type of provider that performs the screening. County health departments, clinics, and private physicians may conduct annual screenings under this program.

Other Optional Services -- A variety of other optional services are available under the North Carolina Medicaid program. Limited services by chiropractors and podiatrists are covered and paid on the basis of a statewide fee schedule. Other optional services include Hospice, Private Duty Nursing,

Ambulance Transportation and Case Management Services to meet the needs of specific groups of Medicaid eligible people.

Maternity/Child Health Initiatives

Providing preventive medical services and basic medical care for North Carolina's mothers and children are a continuing priority for the Medicaid Program. Several times since 1987, the North Carolina General Assembly has authorized Medicaid to take advantage of options in federal law that expand coverage for pregnant women and children with family incomes up to varying percentages of the federal poverty level. For pregnant women and for infants under one year of age, the maximum income to qualify for Medicaid is 185 percent of the federal poverty level. See Table 3 in Appendix A for a description of 2000 Federal Poverty Level amounts.

Medicaid pregnant women who qualify under the Baby Love Program receive comprehensive maternity health care benefits for the duration of their pregnancy through the postpartum period. The infant automatically qualifies for program benefits and is enrolled in the Health Check Program. This program provides coverage for health screenings, immunizations, vision, hearing and dental check-ups on a regular basis. Participants are also eligible to receive medically necessary care to treat any physical or mental condition identified under this program.

States are required to provide coverage to children ages 1 – 5 in families with income below 133 percent of poverty. Also, Federal Law mandates Medicaid coverage for all children above age 6 and born after September 30, 1983 at 100% of poverty. The North Carolina General Assembly authorized the Division of Medical Assistance to take advantage of an option to cover children under 19 years of age at 100 % of the federal poverty level. In SFY 2000, these initiatives helped 79,179 pregnant women and 469,003 children.

SPECIAL PROGRAMS

Baby Love

The Baby Love Program, implemented in October 1987, is designed to help reduce North Carolina's high infant mortality rate by improving access to health care and the service delivery system for low-income pregnant women and children. The Division Of Medical Assistance and the Division of Public Health, Women's and Children's Health Section, jointly administer the Baby Love Program in cooperation with the Office of Research, Demonstrations and Rural Health Development.

Through the Baby Love Program, pregnant women receive comprehensive care from the beginning of pregnancy through the postpartum period. In Federal Fiscal Year 1999, Medicaid covered 40.9% of all deliveries in North Carolina. Infants born to Medicaid-eligible women continue to be eligible until their first birthday.

Specially trained nurses and social workers called Maternity Care Coordinators (MCC's) are located in all 100 North Carolina counties to assist pregnant women in obtaining medical care and an array of social support services such as transportation, housing, job training and day care. In State Fiscal Year 2000, 26,123 pregnant women received MCC services.

In addition to MCC services, Maternal Outreach Workers, specially-trained home visitors, work one-on-one with at-risk families to provide social support, encourage healthy behaviors and ensure

that families are linked with available community resources. Originally funded by the Kate B. Reynolds Healthcare Trust and Medicaid, the Baby Love Maternal Outreach Worker Program has expanded from 21 pilot projects to 69 approved programs located in various agencies across North Carolina.

The benefit package of covered services also has been enriched through the Baby Love Program to include childbirth and parenting classes, in-home skilled nursing care for high-risk pregnancies, nutrition counseling, psychosocial counseling and postpartum/newborn home visits.

Evaluation of the Baby Love Program demonstrates that women who receive the services of a Maternity Care Coordinator average more prenatal visits per pregnancy, have a higher participation in the Women, Infants and Children (WIC) Program and are more likely to receive postpartum family planning services. Likewise, their children are more likely to receive well-child care and WIC services. Mothers who have a Maternity Care Coordinator have better birth outcomes.

The infant mortality rate[1] for Medicaid recipients in North Carolina has fallen from 14.9 in 1987, the year the Baby Love Program started, to 9.25 in 1998, the last year for which we have complete data.

Health Check Program

North Carolina expanded the federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program (which has been in existence since Medicaid began) to form the Health Check Program in 1993. EPSDT serves as the standard for providing healthcare to Medicaid recipients under the age of 21. The purpose of the Health Check Program is to facilitate regular preventive medical care and the diagnosis and treatment of any health problem found during a screening. There is no separate enrollment in Health Check. If someone is eligible for Medicaid and is under the age of 21, they automatically receive Health Check services.

An integral part of the Health Check Program is a special initiative called the Health Check Outreach Project. Sixty-two counties participate in this outreach effort by having specially trained Health Check Coordinators work to reduce barriers and educate families on the importance of preventive health services. Recently, a plan was endorsed by the NC Health Directors' Association to expand Health Check Coordinators statewide. This plan will eventually place health check coordinators in all counties by reallocating existing positions. The Managed Care Section in the Division is the administrative entity for the Health Check Program and coordinators. The Managed Care Section works in close collaboration with The Division of Women and Children's Health to provide guidance to the project counties.

The Health Check Automated Information and Notification System (AINS) is a computerized system for identifying and following Medicaid-eligible children (birth through 20 years of age) with regard to their activities in the health care system. It enables Health Check Coordinators across the state to determine which Medicaid-eligible children in their respective counties are receiving regular and periodic Health Check screenings, immunizations and referrals for special health care problems. The system sends notices to the parents of Medicaid-eligible children, notifying them of the Health

[1] Deaths per 1,000 births. Infant deaths are counted if they occur at birth or anytime during the first year of life.

Check Program, scheduled screening appointments, missed appointments, immunizations and available programs and services. For children enrolled in managed care, the name of the Carolina ACCESS primary care provider appears on letters sent to providers to whom referrals are being made. For children enrolled in an HMO, the name of the managed care plan appears on the letter.

Access to and utilization of health care services for Medicaid eligible children and youth have improved since the initiation of this very important program.

LONG-TERM CARE

Medicaid spends a large portion of its service dollars (38%) on long-term care. Long-term care services comprise nursing facility care, intermediate care facilities for the mentally retarded, adult care home personal care services and a variety of home and community-based services. In SFY 2000, 100,495 people received Medicaid long-term care services in North Carolina costing a total of $1,739,020,113. The average cost per recipient was $17,305 for the year.

Many people consider home and community-based long-term care to be a cost-effective and preferable alternative to institutionalization. Therefore, Medicaid recipients can receive several home-based services such as home health, durable medical equipment and hospice. In addition, North Carolina provides the Community Alternatives Program (described below) as another option for home and community care.

Community Alternatives Program

North Carolina operates four programs to provide home and community care as a cost-effective alternative to institutionalization. These are known as "waiver" programs because standard program requirements are waived to allow the program to operate. The waiver programs provide some services that otherwise are not covered under Medicaid.

CAP/DA Program:

The Community Alternatives Program for Disabled Adults (CAP/DA) provides a package of services to allow adults (age 18 and older) who qualify for nursing facility care to remain in their private residences. The program is available in all North Carolina counties and has served approximately 12,030 people in SFY 2000 at less cost than nursing facility care. The average daily cost of CAP services was less than 75% of the average Medicaid Nursing Facility cost.

CAP-MR/DD:

The Community Alternatives Program for Persons with Mental Retardation or Developmental Disabilities (CAP-MR/DD) provides community services to individuals of any age who qualify for care in an intermediate care facility for the mentally retarded (ICF-MR). The Division of Mental Health, Developmental Disabilities and Substance Abuse Services manages the daily operation of the program under an agreement with DMA. The program is available statewide through local area mental health, developmental disabilities and substance abuse programs. CAP-MR/DD served approximately 5,664 people in SFY 2000 at an average cost that was less than 40% of the average cost of ICF-MR care.

CAP/C:

The Community Alternatives Program for Children (CAP/C) provides cost-effective home care for medically fragile children (through age 18) that would

otherwise require long-term hospital care or nursing facility care. Approximately 337 children participated in CAP/C in SFY 2000. The program contributed to the quality of life for the children and their families/caregivers, while providing care that was cost-effective in comparison to the Medicaid cost for institutional care.

CAP/AIDS:

The Community Alternatives Program for Persons with AIDS (CAP/AIDS) offers a home care alternative to nursing facility care for persons with AIDS as well as children who are HIV-positive with other qualifying conditions. CAP/AIDS is a cooperative effort with the Division of Public Health's AIDS Care Unit. The AIDS Care Unit administers the program with DMA providing oversight. This program began in late 1995 and is still developing statewide. Approximately 40 people were served in SFY 2000 at an average cost significantly less than the average Medicaid cost of nursing facility care.

Overall, the CAP programs have been very successful in giving individuals a choice and maintaining costs at the same time. The programs have allowed those who otherwise would be institutionalized to remain with their family in familiar surroundings. All of these benefits accrued at a cost saving to Medicaid in comparison with the cost of institutional care.

Nursing Facility Care

There are times when nursing facility care is the best option for Medicaid recipients. All Medicaid nursing facilities are required to provide skilled nursing (SN) and intermediate care (IC). Nursing facility reimbursement rates differ based on whether a resident requires skilled or intermediate level of care. In SFY 2000, 31,879 Medicaid recipients received skilled care in a nursing facility costing a total of $421,644,842.

In addition, 23,364 recipients received intermediate care costing a total of $362,600,603. In SFY 2000, Medicaid recipients occupied 70.3% of the nursing facility beds in N.C. See the table below. All Medicaid recipients must have prior approval authorization issued for admission to a nursing facility. There is also a federal requirement for pre-admission screening and annual resident review (PASARR) to screen applicants and residents of Medicaid certified nursing facilities that are suspected of mental illness, mental retardation or conditions related to mental retardation.

Spousal Impoverishment

The Spousal Impoverishment Provision of the Medicare Catastrophic Coverage Act of 1988 allows a spouse living in the community to keep a larger portion of the couple's income when the other spouse requires nursing home care. This allows an institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. The total income and resources amount that may be protected for the at-home spouse increases each year. As of January 1, 2000, the resource protection limit is one half the couples' assets but no less than $16,824 and no more than $84,120. The standard monthly income allowance is $1,407 and can be raised as high as $2,103. (NOTE: The income of the spouse living at home is considered in determining whether an allowance is budgeted).

NURSING FACILITY – LICENSED BEDS AND MEDICAID USAGE			
Year	Nursing Facility Licensed Beds	Medicaid NF Avg. Monthly Recipients	Medicaid Use of Licensed Beds
1995	39,686	29,879	75.3%
1996	40,122	30,679	76.5%
1997	40,625	31,985	78.7%
1998	43,276	33,038	76.3%
1999	39,361	32,800	83.3%
2000	45,973	32,324	70.3%

Adult Care Home Personal Care Services

In the 1995 Legislative Session of the North Carolina General Assembly, coverage began for personal care assistance provided to residents who are eligible for Special Assistance for Adults (SA) and Medicaid. Beginning January 1, 1996, Medicaid covered "enhanced" adult care home personal care (ACH/PC) and adult care home case management services (ACH/CMS) for certain residents of adult care homes who met the Medicaid criteria for being a "heavy care" resident.

The Adult Home Personal Care Services Program served 27,726 residents in SFY 2000 for a total expenditure of $83,103,030.

Medicare-Aid

In February 1989, North Carolina began a new program of healthcare financing assistance to elderly and disabled Medicare beneficiaries, as mandated by federal law. The program, known as Medicare-Aid, allows Medicaid to pay low-income Medicare beneficiaries' cost-sharing expenses, such as deductibles, Medicare premiums and coinsurance charges.

The eligibility income limit for Medicare-Aid is 100 percent of the federal poverty level. Effective January 1, 1993, coverage was added to pay the Medicare B premium for those individuals who are Medicare-Aid eligible having incomes too high to qualify for the basic plan. These individuals are called Specified Low-Income Medicare Beneficiaries. To be eligible, their income must be within 101-120 percent of the federal poverty level.

In January 1998, coverage was expanded to two new groups of Medicare beneficiaries. Individuals with incomes between 120% and 135% of the federal poverty level can qualify for payment of Medicare Part B premiums. Individuals with incomes between 135% and 175% of the federal poverty level can receive reimbursement for a portion of the cost of their Part B premium. The reimbursement amount is set annually by HCFA. These new groups are called "Qualifying Individuals." Federal law mandates their eligibility and funding is capped.

In State Fiscal Year 2000, 14,344 recipients benefited from Medicare-Aid. Total cost for this coverage was $2,184,591.

Drug Use Review Program

North Carolina Medicaid established a Drug Use Review (DUR) Program as required by OBRA of 1990 to ensure that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary and are not likely to result in adverse medical effects.

The DUR program is characterized by the following four major components:

- **DUR Board** - A DUR Board is composed of five licensed and actively practicing physicians, five licensed and actively practicing pharmacists, two other individuals with expertise in drug therapy problems and the DMA DUR Coordinator. The DUR Board makes recommendations to DMA on DUR policies and procedures.

- **Prospective DUR** -- Prospective DUR requires that, prior to dispensing, the pharmacist must screen for potential drug therapy problems and counsel patients about the medications they are taking in order to enhance patient compliance.

- **Retrospective DUR** -- Retrospective DUR is an ongoing periodic examination of Medicaid claims data and other records to identify patterns of behavior involving physicians, pharmacists, and individual Medicaid recipients associated with specific drugs or groups of drugs and the appropriate treatment of disease states. These analyses are based on predetermined standards established by the DUR Board. North Carolina contracted with First Health Services Corporation to provide the computer support for the retrospective DUR.

- **Education** -- Education is the key to an effective DUR Program. The DUR Program must provide ongoing outreach programs to educate physicians and pharmacists about common drug therapy problems with the goal of improved prescribing and dispensing practices.

The Drug Use Review Program uses a Provider Profiling System to complement the retrospective patient-based drug utilization reviews. This system is designed to be a retrospective characterization of drug use patterns. The Provider Profiling System identifies any prescribing and dispensing practices that deviate from accepted norms. These norms may be defined by the Board, taken from published literature or modified as needed. The Provider Profiling System is criteria driven and accommodates client-specific criteria within any of 12 broad problem types.
Since the primary focus of the DUR Program is educating providers about common drug therapy problems to improve prescribing and dispensing practices, the providers who are profiled receive educational letters with profiles of each recipient who receives the medication and prescribing information related to the patient's drug therapy.

Health-Related Services Provided in Public Schools & Head Start Programs

In strengthening the commitment to provide a comprehensive array of services to the children of North Carolina, DMA is paying for physical therapy, occupational therapy, audiological services, speech/language services and psychological services. These services are provided to eligible clients in the public school system by Local Education Agencies (LEA's) or through local Head Start Programs.

Independent Practitioner Program

In addition to the above, the Medicaid program also enrolls and reimburses independent practitioners who provide physical therapy, occupational therapy, respiratory therapy, speech and language therapy, and audiological services to children (birth through 20 years old).

Managed Care

Managed Care

Managed care options for Medicaid recipients are now available in all 100 counties. There are 600,360 Medicaid recipients enrolled in a managed care plan. Options include Carolina ACCESS (which includes ACCESS II and III) and Risk Contracting with State licensed HMOs. All managed care options operate under the authority of 1915(b) of the Social Security Act. Eligibility to participate in a managed care plan is mandatory for a majority of Medicaid recipients in North Carolina. Although recipients of Medicaid/Medicare are optionally enrolled in Carolina ACCESS, they are not enrolled in HMOs. Medicaid recipients who are in long-term care facilities are not enrolled in any managed care plan. Managed care options are as follows:

- **Carolina ACCESS:** A primary care case management model (PCCM), characterized by a primary care physician gatekeeper.
- **ACCESS II & III:** These programs build on the Carolina ACCESS program by working with local providers and networks to better manage the Medicaid population with processes that impact both the quality and cost of healthcare
- **Healthcare Connection:** A program operating in Mecklenburg County requiring mandatory enrollment in an HMO for a majority of Medicaid recipients in that county.
- **Risk Contracting:** DMA contracts with HMOs in selected areas to provide and coordinate medical services for certain Medicaid eligibles on a full risk capitated basis. In these areas, recipients may choose between a participating HMO and Carolina ACCESS. The State of North Carolina must license all HMOs that contract with DMA.

For all of these healthcare models the objectives are:

- Cost-effectiveness
- Appropriate use of healthcare services
- Improved access to primary preventive care

Carolina ACCESS

North Carolina's Patient Access and Coordinated Care Program was designed to provide a more efficient and effective healthcare delivery system for Medicaid recipients. It serves as the foundation of the Managed Care Program for Medicaid in the State. Carolina ACCESS brings a system of coordinated care to the Medicaid Program by linking each eligible recipient with a primary care provider (PCP) who has agreed to provide or arrange for healthcare services for each enrollee. By improving access to primary care and encouraging a stable doctor-patient relationship, the program helps to promote continuity of care, while reducing inappropriate utilization and controlling costs.

The program was implemented in April 1991 through the cooperative efforts of the Division of Medical Assistance and the North Carolina Foundation for Alternative Health Programs. Partial funding was provided through a grant for the Kate B. Reynolds Healthcare Trust.

Five counties were selected for a pilot of the program and by December 1998 expanded to 99 counties (Mecklenburg County does not have Carolina ACCESS). As of June 2000, there were 563,552 Medicaid recipients enrolled in Carolina ACCESS. This is 74.28% of all Medicaid clients eligible in June 2000.

ACCESS II & III

ACCESS II & III were initiated in July 1998 and aim to build on Carolina ACCESS by working with local providers and networks to better manage the Medicaid population with processes that impact both the quality and cost of healthcare. ACCESS II includes local networks comprised of Medicaid providers who have agreed to work together to develop the care management systems and supports that are needed to manage enrollee care. This model also includes a statewide network of large Carolina ACCESS practices who have agreed to work together to develop collaborative systems for managing care. ACCESS III includes countywide plans that are community partnerships involving physicians, hospitals, health departments, departments of social services and other community providers. Networks are assuming responsibility for managing the care of Medicaid eligible populations in the entire county. Plans are distinguished by the following features:

- Local collaboration and community focus to better meet the needs of the Medicaid population
- Population-based and identifying at-risk enrollees
- Implementing targeted care management initiatives
- Developing and measuring defined budget and utilization targets and quality indicators
- Strengthening the community "safety-net" that is in place to serve the expanding indigent population.

Healthcare Connection

Healthcare Connection was implemented in Mecklenburg County in July 1996. It is mandatory for certain Medicaid recipients in Mecklenburg to enroll in an HMO that has contracted with the State. As of June 2000, enrollment in Healthcare Connection stands at 40,267. An evaluation of this program performed by a research team at the University of North Carolina at Charlotte concluded that Healthcare Connection had been cost-effective for the State and county. The evaluation also found patient satisfaction to be high overall with an improved access to general healthcare. In Mecklenburg County, the options for Medicaid recipients are as follows:

- The Wellness Plan
- United Healthcare
- South Care
- C.W. Williams (an FQHC which operates on a fee-for-service basis, but also manages patient care much like Carolina ACCESS)

Risk Contracting

Managed care initiatives in North Carolina began in 1986 when a full-risk contract was signed with Kaiser Permanente to serve AFDC-eligible people in Durham, Mecklenburg, Orange and Wake Counties. In 1997, Kaiser ended its contract with the State, opting to serve Medicaid eligibles as a **Carolina ACCESS** provider in three of the four affected counties. In February 1998, Kaiser ended its participation as a fully capitated health plan option in Mecklenburg County.

The State has entered into contracts with other HMO's and expanded HMO enrollment opportunities to Gaston County Medicaid recipients in the winter of 1997. HMO options were expanded in the Triangle Area during the winter of 1998 and the Triad Area in the fall of 1998.

Total enrollment in HMO's for the optional counties is 541 as of June 2000. The following HMO's have contracted with the State to serve Medicaid recipients as an option with Carolina ACCESS:

- The Wellness Plan

  - Gaston County
- United HealthCare
  - Davidson County
  - Forsyth County
  - Guilford County
  - Rockingham County

Carolina Alternatives Program

Carolina Alternatives was a Mental Health Managed Care model designed to better organize and deliver mental health services to Medicaid eligible infants and children ages 0-17.

Eligible children were linked to area Mental Health Programs that were responsible for providing and/or arranging for all medically necessary mental health and substance abuse services for these children. Each eligible child in need of care received an assessment. A care coordinator then located appropriate community-based services for the child and worked with the child's family and the care provider to develop a plan for treatment.

The program began January 1, 1994, through ten areas Mental Health Programs and was in 32 counties around the state. The development of the program was made possible through a grant from the Kate B. Reynolds Healthcare Trust. The Division of Medical Assistance, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the North Carolina Foundation for Alternative Health Programs and the Office of Rural Area Mental Health Programs collaborated to develop this program. The program ended June 30, 1999 when participating programs concluded that adjusted fee-for-service upper limits were inadequate to meet the cost of rising demand for service.

North Carolina
Health Choice

NC Health Choice for Children

NC Health Choice for Children (NCHC) began enrolling children on October 1, 1998. The program operates under a fee-for-service model that is similar to the NC Teachers and State Employees Comprehensive Major Medical Plan. The base plan is the same as that made available at full premium purchase to the children of State employees and teachers. It is enhanced by vision, dental and hearing benefits and benefits for special needs equivalent to the Medicaid program. The third party administrator of the program is Blue Cross and Blue Shield of North Carolina. Families whose children are not eligible for Medicaid who have been **uninsured for two months** and whose family income is up to **200% of the federal poverty level** are eligible for the program. The highest volume service has been the provision of eyeglasses. The program has averaged filling 32 prescriptions daily for eyeglasses since it began.

As of the end of June 2000, there were 65,129 children enrolled in NCHC. Of these, 68% were from families with an income below 150% of the poverty level and 32% with an income above 150% of the poverty level.

NCHC's enrollment rates are among the best in the United States. In fact, NCHC's efforts have been tagged "cutting edge" by federal officials in HCFA. This is attributed to:

- Active Outreach Coalitions in each of the State's 100 counties
- The county coalition expertise generated in counties through Smart Start
- The commitment on the part of all levels of government to the goal of increasing the numbers of children with health insurance.

Active outreach efforts are underway in all 100 counties. Counties are engaged in outreach in schools, churches, day care centers, minority health clinics, school based health clinics, local industry and local discount retailers and through media efforts including the use of billboards, local radio stations and newspapers. Counties have been given target enrollments.

The majority of NCHC participants are Medicaid "graduates", usually children in families who have begun to earn income too high for Medicaid but who are still within the NCHC limits.

Appendix A

Medicaid Tables

Table 1
North Carolina Medicaid
State Fiscal Year 2000
Federal Matching Rates

Benefit Costs
(7/1/99 - 9/30/99)

	Family Planning	All Other
Federal	90.00%	63.07%
State	8.50%	31.39%
County	1.50%	5.54%
Total	100.00%	100.00%

Benefit Costs
(10/1/99 - 6/30/00)

	Family Planning	All Other
Federal	90.00%	62.49%
State	8.50%	31.88%
County	1.50%	5.63%
Total	100.00%	100.00%

Administrative Costs
(7/1/99 - 6/30/00)

	Skilled Medical Personnel & MMIS*	All Other
Federal	75.00%	50.00%
Non-Federal	25.00%	50.00%
Total	100.00%	100.00%

*MMIS - Medicaid Management Information System

Table 2
North Carolina Medicaid
State Fiscal Year 2000
Medicaid Financial Eligibility Standards

GROUP	FAMILY SIZE:	1	2	3	4	5
Pregnant Women and Children under age 1		$1,288/mo.	$1,755/mo.	$2,182/mo.	$2,629/mo.	$3,076/mo.
	Resource Limit:	None				
Children age 1 through 5	Income Limit:	$926/mo.	$1,247/mo.	$1,569/mo.	$1,890/mo.	$2,212/mo.
	Resource Limit:	None				
Children age 6 through 18	Income Limit:	$696/mo.	$938/mo.	$1,180/mo.	$1,421/mo.	$1,663/mo.
	Resource Limit:	None				
Children age 19 and 20	Income Limit:	$362/mo.	$472/mo.	$544/mo.	$594/mo.	$648/mo.
	Resource Limit:	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
Caretaker Relatives - Individuals (usually parents) who live with children under age 19 to whom they are related when one or both of the child's parents are out of the home, dead, incapacitated or working less than 100 hours a month.	Income Limit:	$362/mo.	$472/mo.	$544/mo.	$594/mo.	$648/mo.
	Resource Limit:	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
Aged (over age 65), **Blind** or **Disabled** by Social Security standards.	Income Limit:	$696/mo.	$938/mo.			
	Resource Limit:	$ 2,000	$ 3,000			
Medicare Beneficiaries - Persons who have Medicare Part A -						
* Medicaid pays for Medicare premiums, deductibles and co-payments.	Income Limit:	$696/mo.	$938/mo.			
	Resource Limit:	$ 4,000	$ 6,000			
* Medicaid pays Medicare Part B premiums only.	Income Limit:	$835/mo.	$1,125/mo.			
	Resource Limit:	$ 4,000	$ 6,000			
Deductible/Spendown - Individuals who do not meet the income limits specified above and who have high medical bills may be eligible for Medicaid after meeting a deductible.	The deductible is based on how much the monthly income exceeds this	$242/mo.	$317/mo.	$367/mo.	$400/mo.	$433/mo.
	Resource Limit:					
	Families & Children	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
	Aged,Blind,Disabled	$ 2,000	$ 3,000			

Table 3
Financial Eligibility for Medicaid based on
Percentage of Poverty (Annual)
SFY 2000

Family Size	100%	120%	133%	135%	185%	200%	SSI	MNIL	SA
1	$ 8,352	$ 10,020	$ 11,112	$ 11,280	$ 15,456	$ 16,704	$ 6,144	$ 2,904	$ 11,784
2	$ 11,256	$ 13,500	$ 14,964	$ 15,192	$ 20,820	$ 22,500	$ 9,228	$ 3,804	
3	$ 14,160		$ 18,828		$ 26,184	$ 28,308			
4	$ 17,052		$ 22,680		$ 31,548	$ 34,104			
5	$ 19,956		$ 26,544		$ 36,912	$ 39,900			

Table 4
North Carolina Medicaid
State Fiscal Year 2000
Enrolled Medicaid Providers

Providers	Number
Physicians*	33,787
Dentists	3,715
Pharmacists	2,203
Optometrists	1,398
Chiropractors	1,364
Podiatrists	470
Ambulance Companies	368
Home Health Agencies**	180
Durable Medical Equipment Suppliers	4,134
Intermediate Care Facilities-MR	330
HMOs	5
Hospitals	626
Mental Health Clinics	198
Nursing Facilities	965
Domicile Care	2,394
Personal Care Agencies	607
Rural Health Clinics	146
CRNA	70
Nurse Midwives	64
Hospices	73
CAP Providers	910
Other Clinics	11
Other	5,271
Total	**59,289**

* The count of physicians reflects each provider number assigned to an individual physician or a group practice of physicians. Most physicians practicing in a group have an individual provider number in addition to the group number. Also, physicians who practice in multiple settings are included once for each practice setting.

**Includes Physical, Speech, Occupational and Home Infusion Therapy services.

Table 5
North Carolina Medicaid
State Fiscal Year 2000
Medicaid Covered Services

1 Ambulance Transportation
2 Case Management for:
    * Pregnant women
    * High risk children (0-5)
    * Chronically mentally ill adults
    * Emotionally disturbed children
    * Chronic substance abusers
    * Adults & Children at risk of abuse, neglect, or exploitation
    * Persons with HIV Disease
3 Chiropractors
4 Clinic Services
5 Community Alternatives Programs (CAP)
6 Dental Care Services
7 Domicile Care
8 Durable Medical Equipment
9 Health Check Services (EPSDT)
10 Family Planning Services
11 Hearing Aids (for children)
12 HMO Membership
13 Home Health Services
14 Home Infusion Therapy Services
15 Hospice
16 Inpatient & Outpatient Hospital Services
17 Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
18 Laboratory & X-Ray Services
19 Mental Hospitals (age 65 & over)
20 Migrant Health Clinics
21 Nurse Midwives
22 Nurse Practitioners
23 Nursing Facilities (NF)
24 Optical Supplies
25 Optometrists
26 Personal Care Services
27 Physicians
28 Podiatrists
29 Prepaid Health Plan Services
30 Prescription Drugs
31 Private Duty Nursing Services
32 Prosthetics and Orthotics (children)
33 Rehabilitative Services (under the auspices of area mental health programs)
34 Rural Health Clinics
35 Specialty Hospitals
36 Transportation

Table 6
North Carolina Medicaid
State Fiscal Year 1999 & 2000
Sources of Medicaid Funds

	SFY 1999	Percent	SFY 2000	Percent
Federal	$ 2,988,767,566	60.6%	$ 3,405,578,752	58.8%
State*	$ 1,301,768,010	26.4%	$ 1,429,745,564	24.7%
Other State	$ 417,445,559	8.5%	$ 661,374,876	11.4%
County	$ 226,155,462	4.6%	$ 213,520,774	3.7%
Admin -Other	not available		$ 78,913,119	1.4%
Total	**$ 4,934,136,597**	**100.0%**	**$ 5,789,133,085**	**100.0%**

* State appropriation of funds

Source: BD701, The Authorized Monthly Budget Report for the period ending June 29, 2000

Table 7
North Carolina Medicaid
State Fiscal Year 2000
Uses of Medicaid Funds

Type of Service	Total Expenditures	Percent of Total Dollars	Percent of Svc. Dollars	Users of Services*	Cost Per Service User
Inpatient Hospital	736,135,229	12.7%	15.3%	188,441	$ 3,906
Outpatient Hospital	272,258,247	4.7%	5.7%	511,679	532
Mental Hospital >65 & <21	23,063,625	0.4%	0.5%	2,547	9,055
Physician	432,332,656	7.5%	9.0%	1,022,362	423
Clinics	303,962,885	5.3%	6.3%	298,971	1,017
Nursing Facility (Skilled)	423,583,541	7.3%	8.8%	29,462	14,377
Nursing Facility (Intermediate)	386,455,052	6.7%	8.1%	23,627	16,357
ICF-MR	382,313,189	6.6%	8.0%	4,757	80,369
Dental	57,586,942	1.0%	1.2%	219,902	262
Prescription Drugs	754,505,194	13.0%	15.7%	817,779	923
Home Health	120,042,028	2.1%	2.5%	81,624	1,471
All Other Services	687,236,522	11.9%	14.3%	758,628	906
Subtotal Services	**$ 4,579,475,109**	**79.1%**	**95.5%**		
Medicare Premiums:					
(Part A, Part B, QMB, Dually Eligible)	165,457,105	2.9%	3.4%		
HMO Premiums	51,750,006	0.9%	1.1%		
Subtotal Services & Premiums	**$ 4,796,682,219**				
Adjustments, Cost Settlements & Transfers	283,682,693	4.9%			
Disproportionate Share Payments	374,257,526	6.5% **			
Transfer to State Treasurer	106,170,396	1.8%			
Subtotal Services, Premiums & Other	**$ 5,560,792,834**	**96.1%**			
DMA Administration	**69,251,716**	**1.2%**			
DMA Total Expenditures	**$ 5,630,044,550**	**97.3%**			
Admin Costs of other DHHS agencies for which Medicaid Federal match was received, including county administration.	**$ 159,088,535**	**2.7%**			
Grand Total Medicaid Related Expenditures	**$ 5,789,133,085**	**100.0%**			
Total Recipients (unduplicated)* **				**1,200,906**	
Total Expenditures Per Recipient (unduplicated)					**$ 4,821**

* "Users of Services" is a Duplicated Count. Recipients using one or more services are counted in each service category.
** Additional payments for hospitals providing services to a higher than average number of medicaid patients.
*** "Total Recipients" is unduplicated, counting recipients only once during the year regardless of the number or type of services they use.

Note: Numbers may not add due to rounding.
SOURCES: State 2082 Report -SFY 2000, PER Report YTD June 2000, BD701 Report June 2000 and HCFA-64 quarterly reports covering SFY 2000.
Note: Users of Services in All Other Services is obtained from the State History table by taking a nonduplicated count of the number of users.

Table 8
North Carolina Medicaid
A History of Medicaid Expenditures
SFYs 1979-2000

Fiscal Year	Expenditures	Percentage Change
1979	$ 379,769,848	N/A
1980	$ 410,053,625	8%
1981	$ 507,602,694	24%
1982	$ 521,462,961	3%
1983	$ 570,309,294	9%
1984	$ 657,763,927	15%
1985	$ 665,526,678	1%
1986	$ 758,115,890	14%
1987	$ 861,175,819	14%
1988	$ 983,464,113	14%
1989	$ 1,196,905,351	22%
1990	$ 1,427,672,567	19%
1991	$ 1,942,016,092	36%
1992	$ 2,478,709,587	28%
1993	$ 2,836,335,468	14%
1994	$ 3,550,099,377	25%
1995	$ 3,550,468,230	0%
1996	$ 4,113,344,777	16%
1997	$ 4,640,421,917	13%
1998	$ 4,715,733,033	2%
1999	$ 4,934,136,597	5%
2000	$ 5,789,133,085	17%

Table 9
North Carolina Medicaid
State Fiscal Years 1979-2000
A History of Medicaid Eligibles

Fiscal Year	Aged	Qualified Medicare Beneficiaries	Blind	Disabled	AFDC Adults & Children	Medicaid Pregnant Women	Medicaid Indigent Children	Other Children	Aliens and Refugees	Total	Percent Change
1978-79	82,930	N/A	3,219	59,187	301,218	N/A	N/A	6,620	N/A	453,174	-
1979-80	82,859	N/A	2,878	56,265	307,059	N/A	N/A	6,641	N/A	455,702	0.60%
1980-81	80,725	N/A	2,656	56,773	315,651	N/A	N/A	6,559	N/A	459,364	0.80%
1981-82	70,010	N/A	2,349	48,266	298,483	N/A	N/A	6,125	N/A	425,233	-7.40%
1982-83	67,330	N/A	2,000	46,537	293,623	N/A	N/A	6,062	N/A	415,552	-2.30%
1983-84	65,203	N/A	1,755	46,728	288,619	N/A	N/A	5,501	N/A	407,806	-1.90%
1984-85	65,849	N/A	1,634	48,349	293,188	N/A	N/A	5,333	N/A	414,353	1.60%
1985-86	69,193	N/A	1,554	51,959	313,909	N/A	N/A	5,315	N/A	441,930	6.70%
1986-87	72,295	N/A	1,462	54,924	317,983	N/A	N/A	5,361	N/A	452,025	2.30%
1987-88	76,308	N/A	1,394	58,258	323,418	9,842	6,543	5,563	N/A	481,326	6.50%
1988-89	80,044	19,064	1,304	62,419	352,321	20,277	19,615	6,009	561	561,614	16.70%
1989-90	80,266	33,929	1,220	64,875	387,882	28,563	36,429	5,176	1,011	639,351	13.80%
1990-91	81,466	42,949	1,116	70,397	451,983	37,200	61,210	4,296	1,675	753,292	17.80%
1991-92	83,337	56,871	1,064	79,282	513,023	43,330	94,922	4,139	1,955	877,923	16.50%
1992-93	85,702	71,120	1,003	87,664	562,661	45,629	132,348	4,133	2,437	992,697	13.10%
1993-94	86,111	83,460	929	90,889	581,397	46,970	162,417	4,100	2,330	1,058,603	6.60%
1994-95	127,514	48,373	2,716	155,215	533,300	48,115	216,888	3,808	2,857	1,138,786	7.60%
1995-96	131,496	53,072	2,710	171,204	496,501	52,466	261,525	3,696	3,919	1,176,589	3.32%
1996-97	132,173	58,036	2,593	176,160	462,881	55,838	295,882	3,747	4,823	1,192,133	1.30%
1997-98	131,332	61,032	2,531	180,461	414,853	58,899	337,849	3,905	6,311	1,197,173	0.42%
1998-99	152,582	32,737	2,497	199,523	344,621	60,896	371,986	3,941	8,036	1,176,819	-1.73%
1999-00	154,222	33,302	2,428	205,205	330,113	60,918	421,158	4,063	9,857	1,221,266	3.64%
SFY 1999 Percent Total Eligibles:	13.0%	2.8%	0.2%	17.0%	29.3%	5.2%	31.6%	0.3%	0.7%	100.0%	
SFY 2000 Percent Total Eligibles:	12.6%	2.7%	0.2%	16.8%	27.0%	5.0%	34.5%	0.3%	0.8%	100.0%	

Source: Medicaid Eligibilty Report, EJA752-SFY 2000

Table 10
North Carolina Medicaid
State Fiscal Year 2000
Total Expenditures and Eligibles by County

COUNTY NAME	2000 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES	TOTAL EXPENDITURES	EXPEND. PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	PER CAPITA EXPENDITURE RANKING	ELIGIBLES PER 1,000 POPULATION	% of Medicaid Eligibles by County Based on 2000 Population
ALAMANCE	124,042	16,439	$ 67,418,365	**$ 4,101**	**$ 544**	78	**133**	13.25%
ALEXANDER	32,530	4,423	$ 17,446,612	**3,945**	**536**	80	**136**	13.60%
ALLEGHANY	9,966	1,641	$ 8,463,094	**5,157**	**849**	34	**165**	16.47%
ANSON	23,844	6,585	$ 26,374,764	**4,005**	**1,106**	10	**276**	27.62%
ASHE	23,966	4,482	$ 22,297,228	**4,975**	**930**	25	**187**	18.70%
AVERY	15,964	2,811	$ 16,008,614	**5,695**	**1,003**	20	**176**	17.61%
BEAUFORT	44,158	10,028	$ 40,580,635	**4,047**	**919**	27	**227**	22.71%
BERTIE	19,830	6,384	$ 25,286,195	**3,961**	**1,275**	4	**322**	32.19%
BLADEN	30,924	9,327	$ 38,571,591	**4,135**	**1,247**	6	**302**	30.16%
BRUNSWICK	69,577	12,651	$ 45,749,344	**3,616**	**658**	59	**182**	18.18%
BUNCOMBE	194,353	30,841	$ 130,378,658	**4,227**	**671**	56	**159**	15.87%
BURKE	84,583	12,919	$ 60,851,819	**4,710**	**719**	50	**153**	15.27%
CABARRUS	125,051	14,594	$ 64,485,486	**4,419**	**516**	84	**117**	11.67%
CALDWELL	75,882	11,697	$ 49,256,223	**4,211**	**649**	61	**154**	15.41%
CAMDEN	6,748	918	$ 3,662,938	**3,990**	**543**	79	**136**	13.60%
CARTERET	59,120	7,913	$ 33,047,772	**4,176**	**559**	76	**134**	13.38%
CASWELL	22,440	3,898	$ 16,416,361	**4,211**	**732**	47	**174**	17.37%
CATAWBA	134,128	17,813	$ 64,475,434	**3,620**	**481**	91	**133**	13.28%
CHATHAM	47,264	5,454	$ 23,418,599	**4,294**	**495**	86	**115**	11.54%
CHEROKEE	23,072	5,131	$ 23,935,880	**4,665**	**1,037**	15	**222**	22.24%
CHOWAN	14,036	3,439	$ 14,838,220	**4,315**	**1,057**	13	**245**	24.50%
CLAY	8,412	1,436	$ 6,428,632	**4,477**	**764**	37	**171**	17.07%
CLEVELAND	92,590	17,118	$ 69,642,465	**4,068**	**752**	42	**185**	18.49%
COLUMBUS	52,476	16,018	$ 67,322,792	**4,203**	**1,283**	3	**305**	30.52%
CRAVEN	89,730	14,572	$ 55,589,936	**3,815**	**620**	67	**162**	16.24%
CUMBERLAND	291,897	48,210	$ 142,461,587	**2,955**	**488**	90	**165**	16.52%
CURRITUCK	17,496	2,315	$ 7,608,372	**3,287**	**435**	94	**132**	13.23%
DARE	28,918	2,813	$ 12,367,657	**4,397**	**428**	96	**97**	9.73%
DAVIDSON	142,722	19,670	$ 74,630,887	**3,794**	**523**	83	**138**	13.78%
DAVIE	32,968	3,641	$ 16,090,796	**4,419**	**488**	89	**110**	11.04%
DUPLIN	44,502	10,787	$ 39,746,244	**3,685**	**893**	29	**242**	24.24%
DURHAM	203,357	29,817	$ 121,905,044	**4,088**	**599**	71	**147**	14.66%
EDGECOMBE	54,034	16,783	$ 54,467,810	**3,245**	**1,008**	19	**311**	31.06%
FORSYTH	291,846	37,481	$ 142,696,244	**3,807**	**489**	88	**128**	12.84%
FRANKLIN	45,332	8,051	$ 32,458,100	**4,032**	**716**	51	**178**	17.76%
GASTON	181,362	30,463	$ 124,360,336	**4,082**	**686**	53	**168**	16.80%
GATES	10,114	1,736	$ 7,676,680	**4,422**	**759**	39	**172**	17.16%
GRAHAM	7,522	1,981	$ 9,805,931	**4,950**	**1,304**	2	**263**	26.34%
GRANVILLE	45,450	6,714	$ 29,994,336	**4,467**	**660**	58	**148**	14.77%
GREENE	18,298	3,890	$ 15,052,148	**3,869**	**823**	35	**213**	21.26%
GUILFORD	393,423	56,278	$ 210,668,733	**3,743**	**535**	81	**143**	14.30%
HALIFAX	54,752	17,884	$ 58,516,298	**3,272**	**1,069**	11	**327**	32.66%
HARNETT	85,305	16,516	$ 54,323,900	**3,289**	**637**	63	**194**	19.36%
HAYWOOD	52,096	8,797	$ 36,077,714	**4,101**	**693**	52	**169**	16.89%
HENDERSON	82,365	12,272	$ 50,994,670	**4,155**	**619**	68	**149**	14.90%
HERTFORD	21,260	6,962	$ 26,568,655	**3,816**	**1,250**	5	**327**	32.75%
HOKE	31,102	7,154	$ 23,187,001	**3,241**	**746**	44	**230**	23.00%
HYDE	5,611	1,253	$ 5,940,432	**4,741**	**1,059**	12	**223**	22.33%
IREDELL	117,804	14,997	$ 55,537,580	**3,703**	**471**	92	**127**	12.73%
JACKSON	29,806	5,161	$ 22,155,688	**4,293**	**743**	45	**173**	17.32%
JOHNSTON	112,154	18,939	$ 67,613,142	**3,570**	**603**	70	**169**	16.89%
JONES	9,305	2,107	$ 8,750,207	**4,153**	**940**	23	**226**	22.64%
LEE	49,247	8,720	$ 30,742,175	**3,525**	**624**	65	**177**	17.71%
LENOIR	58,208	14,293	$ 57,514,236	**4,024**	**988**	21	**246**	24.56%

Table 10 (Cont.)
North Carolina Medicaid
State Fiscal Year 2000
Total Expenditures and Eligibles by County

COUNTY NAME	2000 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES	TOTAL EXPENDITURES	EXPEND. PER ELIGIBLE	PER CAPTIA EXPENDITURE AMOUNT	PER CAPTIA EXPENDITURE RANKING	ELIGIBLES PER 1,000 POPULATION	% of Medicaid Eligibles by County Based on 2000 Population
LINCOLN	60,080	7,826	$ 31,876,484	**$ 4,073**	**$ 531**	82	**130**	13.03%
MACON	40,644	4,882	$ 18,573,836	**3,805**	**457**	93	**120**	12.01%
MADISON	28,630	3,760	$ 15,656,807	**4,164**	**547**	77	**131**	13.13%
MARTIN	18,978	6,639	$ 26,945,373	**4,059**	**1,420**	1	**350**	34.98%
MCDOWELL	25,708	6,599	$ 26,390,634	**3,999**	**1,027**	16	**257**	25.67%
MECKLENBURG	642,245	80,442	$ 270,898,502	**3,368**	**422**	98	**125**	12.53%
MITCHELL	14,690	2,593	$ 12,736,144	**4,912**	**867**	31	**177**	17.65%
MONTGOMERY	24,988	5,198	$ 18,853,623	**3,627**	**755**	41	**208**	20.80%
MOORE	72,308	9,993	$ 40,503,740	**4,053**	**560**	75	**138**	13.82%
NASH	89,064	15,764	$ 56,481,147	**3,583**	**634**	64	**177**	17.70%
NEW HANOVER	148,822	22,002	$ 92,208,401	**4,191**	**620**	66	**148**	14.78%
NORTHAMPTON	20,949	6,720	$ 24,997,088	**3,720**	**1,193**	8	**321**	32.08%
ONSLOW	148,286	17,895	$ 55,999,521	**3,129**	**378**	99	**121**	12.07%
ORANGE	109,746	8,284	$ 39,064,403	**4,716**	**356**	100	**75**	7.55%
PAMLICO	12,602	2,506	$ 11,139,101	**4,445**	**884**	30	**199**	19.89%
PASQUOTANK	34,650	7,510	$ 26,185,135	**3,487**	**756**	40	**217**	21.67%
PENDER	38,971	7,095	$ 29,760,033	**4,195**	**764**	38	**182**	18.21%
PERQUIMANS	10,872	2,378	$ 7,864,865	**3,307**	**723**	49	**219**	21.87%
PERSON	33,664	5,630	$ 25,247,346	**4,484**	**750**	43	**167**	16.72%
PITT	127,879	23,745	$ 82,578,489	**3,478**	**646**	62	**186**	18.57%
POLK	16,925	2,237	$ 9,746,675	**4,357**	**576**	74	**132**	13.22%
RANDOLPH	126,316	17,277	$ 62,249,779	**3,603**	**493**	87	**137**	13.68%
RICHMOND	45,158	11,916	$ 46,044,781	**3,864**	**1,020**	17	**264**	26.39%
ROBESON	115,333	38,413	$ 141,335,272	**3,679**	**1,225**	7	**333**	33.31%
ROCKINGHAM	89,745	15,457	$ 65,403,690	**4,231**	**729**	48	**172**	17.22%
ROWAN	125,800	18,673	$ 72,457,939	**3,880**	**576**	73	**148**	14.84%
RUTHERFORD	60,508	11,399	$ 44,643,189	**3,916**	**738**	46	**188**	18.84%
SAMPSON	54,155	13,648	$ 50,349,692	**3,689**	**930**	26	**252**	25.20%
SCOTLAND	34,824	10,533	$ 39,137,559	**3,716**	**1,124**	9	**302**	30.25%
STANLY	56,082	8,442	$ 37,028,154	**4,386**	**660**	57	**151**	15.05%
STOKES	43,700	5,271	$ 21,711,856	**4,119**	**497**	85	**121**	12.06%
SURRY	68,843	11,205	$ 46,281,005	**4,130**	**672**	55	**163**	16.28%
SWAIN	12,311	3,015	$ 11,647,118	**3,863**	**946**	22	**245**	24.49%
TRANSYLVANIA	28,353	4,211	$ 18,597,648	**4,416**	**656**	60	**149**	14.85%
TYRRELL	4,025	1,028	$ 4,087,498	**3,976**	**1,016**	18	**255**	25.54%
UNION	115,344	13,665	$ 49,180,952	**3,599**	**426**	97	**118**	11.85%
VANCE	42,271	12,254	$ 38,475,761	**3,140**	**910**	28	**290**	28.99%
WAKE	592,218	51,532	$ 177,793,900	**3,450**	**300**	101	**87**	8.70%
WARREN	18,978	5,090	$ 17,764,402	**3,490**	**936**	24	**268**	26.82%
WASHINGTON	12,850	3,754	$ 13,336,413	**3,553**	**1,038**	14	**292**	29.21%
WATAUGA	40,791	3,547	$ 17,506,188	**4,935**	**429**	95	**87**	8.70%
WAYNE	112,954	22,142	$ 77,046,045	**3,480**	**682**	54	**196**	19.60%
WILKES	63,760	10,718	$ 49,613,677	**4,629**	**778**	36	**168**	16.81%
WILSON	69,772	16,302	$ 59,377,302	**3,642**	**851**	33	**234**	23.36%
YADKIN	36,124	4,678	$ 20,993,600	**4,488**	**581**	72	**129**	12.95%
YANCEY	16,841	3,181	$ 14,385,158	**4,522**	**854**	32	**189**	18.89%
STATE TOTAL	7,650,699	1,221,266	$ 4,652,016,181	**$ 3,809**	**$ 608**	N/A	**160**	15.96%

Source: Medicaid Cost Calculation Fiscal YTD June 2000.
Note: Data reflect only net vendor payments for which the county is billed for its computable share.

Table 11
North Carolina Medicaid
State Fiscal Year 2000
Medicaid Service Expenditures by Recipient Group

Eligibility Group	Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 2000 Expenditures Per Recipient	SFY 1999 Expenditures Per Recipient	99/00 Percent Change
Total Elderly	**$ 1,559,417,908**	**32.5%**	**162,533**	**13.5%**	**$ 9,594**	**$ 8,318**	**15.3%**
Aged	1,541,163,711	32.1%	149,027	12.4%	10,342	10,316	0.2%
Medicare-Aid (MQBQ & MQBB)	18,254,197	0.4%	13,506	1.1%	1,352	1,226	10.2%
Total Disabled	**$ 2,016,505,902**	**42.0%**	**204,232**	**17.0%**	**9,874**	**9,276**	**6.4%**
Disabled	1,991,190,933	41.5%	201,878	16.8%	9,863	9,270	6.4%
Blind	25,314,969	0.5%	2,354	0.2%	10,754	9,744	10.4%
Total Families &Children	**$ 1,212,330,805**	**25.3%**	**825,296**	**68.7%**	**1,469**	**1,402**	**4.8%**
AFDC Adults (> 21)	276,192,007	5.8%	137,190	11.4%	2,013	1,634	23.2%
Medicaid Pregnant Women Coverage(MPW)	199,041,760	4.1%	72,766	6.1%	2,735	2,680	2.1%
AFDC Children & Other Children	267,542,973	5.6%	200,188	16.7%	1,336	1,264	5.7%
Medicaid Indigent Children(MIC)	469,554,064	9.8%	415,152	34.6%	1,131	1,146	-1.3%
Aliens and Refugees	**$ 26,993,251**	**0.6%**	**8,845**	**0.7%**	**3,052**	**2,844**	**7.3%**
Adjustments Not Attributable To A Specific Category	**$ (18,565,646)**	**-0.4%**					
Total Service Expenditures All Groups	**$ 4,796,682,219**	**100.0%**	**1,200,906**	**100.0%**	**3,994**	**$ 3,669**	**8.9%**

Note:Total Service Expenditures does not include:

Disproportionate Share Payments	$ 374,257,526
State & County administrative costs	69,251,716
Transfer to State Treasurer	106,170,396
Adjustments and cost settlements	283,682,693
TOTAL	$ 833,362,331

See Table 6 for more details regarding all sources of Medicaid funds.
Source: SFY 2000 Program Expenditure Report and 2082 Report.

Table 12
North Carolina Medicaid
State Fiscal Year 2000
Service Expenditures For Selected Major Medical Services By Program Category

Type of Service	Total	Percent of Service Dollars	Aged	MQBQ* Qualified Medicare Beneficiary	MQBB+MQBE Part B Premium Only	Blind	Disabled	Other Adult**	Children***	Aliens & Refugees	Adjustments Unattributable To A Specific Category
Inpatient Hospital	$ 736,135,229	15.3%	$ 19,851,551	$ 224,869	$ -	$ 2,445,500	$ 326,859,313	$ 165,494,842	$206,386,653	$ 19,718,213	$ (4,845,713)
Outpatient Hospital	272,258,247	5.7%	31,162,668	783,464	-	951,355	113,552,563	65,473,256	64,236,173	584,389	(4,485,620)
Mental Hospital (> 65)	8,597,352	0.2%	8,602,439	3,686	-	(8,581)	-	-	-	-	(192)
Psychiatric Hospital (< 21)	14,466,273	0.3%	-	-	-	2,638	4,057,773	17,795	10,416,560	-	(28,492)
Physician	432,332,656	9.0%	50,133,695	881,015	361	1,185,587	134,109,172	103,578,481	139,700,839	5,596,917	(2,853,412)
Clinics	303,962,885	6.3%	11,091,768	176,817	519	709,487	140,018,774	38,197,015	116,424,202	709,852	(3,365,549)
Nursing Facility:											
Skilled Level	423,583,541	8.8%	366,198,705	3,743	-	1,265,457	56,400,310	47,059	22,268	114	(354,116)
Intermediate Level	386,455,052	8.1%	353,256,340	310	-	1,362,946	31,876,238	795	79,337	5,300	(126,214)
Intermediate Care Facility (Mentally Retarded)	382,313,189	8.0%	18,698,319	-	-	6,765,399	353,444,238	31,592	3,408,490	-	(34,849)
Dental	57,586,942	1.2%	7,136,065	559	-	113,251	15,660,781	9,093,549	25,534,095	173,957	(125,316)
Prescription Drugs	754,505,194	15.7%	270,072,626	-	-	3,228,032	359,524,944	51,187,512	70,723,821	79,912	(311,653)
Home Health	120,042,028	2.5%	24,048,066	6,017	-	1,065,056	81,399,927	4,656,961	9,348,285	24,354	(506,639)
CAP/Disabled Adult	172,223,094	3.6%	131,628,916	-	-	1,368,543	39,541,357	-	-	-	(315,723)
CAP/Mentally Retarded	181,279,890	3.8%	3,364,453	-	-	1,841,117	174,476,063	-	2,041,703	-	(443,446)
CAP/Children	12,324,578	0.3%	-	-	-	-	11,980,624	-	349,689	-	(5,735)
Personal Care	92,949,966	1.9%	67,432,998	1,311	-	1,124,325	24,271,355	350,898	145,214	852	(376,988)
Hospice	9,697,636	0.2%	4,295,852	-	-	18,669	5,164,068	183,393	81,970	-	(46,316)
EPSDT (Health Check)	34,517,253	0.7%	463	-	-	6,688	1,096,275	31,323	33,437,265	8,727	(63,487)
Lab & X-ray	12,901,530	0.3%	71,684	602	-	33,783	3,050,463	5,461,794	4,283,310	23,582	(23,688)
Adult Home Care	86,941,136	1.8%	52,975,641	3,773	29,604	274,069	33,685,057	3,005	8,967	-	(38,979)
Other Services	84,401,440	1.8%	9,895,168	67,941	-	232,862	28,544,439	18,961,288	26,898,198	63,968	(262,425)
Total Services	**4,579,475,109**	**95.5%**	**1,429,917,417**	**2,154,106**	**30,484**	**23,986,184**	**1,938,713,734**	**462,770,558**	**713,527,038**	**26,990,137**	**(18,614,550)**
Medicaire:											
Part A Premiums	40,608,106	0.8%	40,101,992	19,187	-	609,176	6,076	-	-	-	(128,325)
Part B Premiums	124,848,999	2.6%	71,144,225	1,058,808	14,991,611	546,607	36,666,148	255,181	9,282	(91)	177,228
HMO Premiums	51,750,006	1.1%	78	-	-	173,001	15,804,976	12,208,030	23,560,717	3,204	-
Total Premiums	**217,207,110**	**4.5%**	**111,246,294**	**1,077,995**	**14,991,611**	**1,328,785**	**52,477,200**	**12,463,210**	**23,569,999**	**3,113**	**48,903**
Grand Total Services and Premiums	**$ 4,796,682,219**		**$ 1,541,163,711**	**$ 3,232,101**	**$ 15,022,095**	**$ 25,314,969**	**$ 1,991,190,933**	**$ 475,233,768**	**$ 737,097,037**	**26,993,251**	**(18,565,646)**

Note: Grand Total Expenditures do not include adjustments processed by DMA, settlements, Disproportionate Share Costs and State and County Administration costs.

* Reflects expenditures for those who were eligible as QMBs at the end of the year. As a result, expenditures include more services than are available through QMB coverage.(Medicare-covered services only.)

** Includes individuals covered under SOBRA Pregnant Women policies or individuals age 21 & Over under TANF or AFDC Related coverage.

*** Includes SOBRA Children,individuals under age 21 in TANF or AFDC Related coverages, or Other Children in Foster Care.

Table13
North Carolina Medicaid
State Fiscal Year 2000
Expenditures For The Elderly

Type of Service	Aged	Percent of Service Dollars	MQBQ* Qualified Medicare Beneficiary	MQBB+MQBE Part B Premium Only	Total Qualified Medicare Beneficieries	Percent of Service Dollars	Total Elderly Dollars	SFY 2000 % of Total Dollars	SFY 1999 % of Total Dollars	SFY 1998 % of Total Dollars
Inpatient Hospital	$ 19,851,551	1.3%	$ 224,869	-	$ 224,869	1.2%	$ 20,076,420	1.3%	1.2%	1.1%
Outpatient Hospital	31,162,668	2.0%	783,464	-	783,464	4.3%	31,946,132	2.0%	2.2%	2.2%
Mental Hospital (> 65)	8,602,439	0.6%	3,686	-	3,686	0.0%	8,606,125	0.6%	0.6%	0.7%
Physician	50,133,695	3.3%	881,015	361	881,376	4.8%	51,015,071	3.3%	3.6%	4.1%
Clinics	11,091,768	0.7%	176,817	519	177,336	1.0%	11,269,105	0.7%	0.9%	1.2%
Nursing Facility:										
Skilled Level	366,198,705	23.8%	3,743	-	3,743	0.0%	366,202,448	23.5%	26.5%	27.8%
Intermediate Level	353,256,340	22.9%	310	-	310	0.0%	353,256,651	22.7%	23.0%	23.2%
Intermediate Care Facility: (Mentally Retarded)	18,698,319	1.2%	-	-	-	0.0%	18,698,319	1.2%	1.2%	1.1%
Dental	7,136,065	0.5%	559	-	559	0.0%	7,136,624	0.5%	0.4%	0.4%
Prescription Drugs	270,072,626	17.5%	-	-	-	0.0%	270,072,626	17.3%	13.9%	12.0%
Home Health	24,048,066	1.6%	6,017	-	6,017	0.0%	24,054,084	1.5%	1.5%	1.1%
CAP/Disabled Adult	131,628,916	8.5%	-	-	-	0.0%	131,628,916	8.4%	8.1%	7.6%
CAP/Mentally Retarded	3,364,453	0.2%	-	-	-	0.0%	3,364,453	0.2%	0.2%	0.2%
Personal Care	67,432,998	4.4%	1,311	-	1,311	0.0%	67,434,308	4.3%	3.7%	3.8%
Hospice	4,295,852	0.3%	-	-	-	0.0%	4,295,852	0.3%	0.3%	0.3%
EPSDT (Health Check)	463	0.0%	-	-	-	0.0%	463	0.0%	0.0%	0.0%
Lab & X-ray	71,684	0.0%	602	-	602	0.0%	72,286	0.0%	0.0%	0.0%
Adult Home Care	52,975,641	3.4%	3,773	29,604	33,377	0.2%	53,009,018	3.4%	3.1%	3.0%
Other Services	9,895,168	0.6%	67,941	-	67,941	0.4%	9,963,109	0.6%	0.7%	0.6%
Total Services	**$ 1,429,917,417**	**92.8%**	**2,154,106**	**30,484**	**2,184,591**	**12.0%**	**1,432,102,008**	**91.8%**	**91.0%**	**90.5%**
Medicare, Part A Premiums	40,101,992	2.6%	19,187	-	19,187	0.1%	40,121,179	2.6%	2.9%	3.1%
Medicare, Part B Premiums	71,144,225	4.6%	1,058,808	14,991,611	16,050,419	87.9%	87,194,644	5.6%	6.1%	6.4%
HMO Premiums	78	0.0%	-	-	-	0.0%	78	0.0%	0.0%	0.0%
Total Premiums	**$ 111,246,294**		**1,077,995**	**14,991,611**	**16,069,606**		**127,315,900**			
Grand Total Services & Premiums	**$ 1,541,163,711**	**100.0%**	**3,232,101**	**15,022,095**	**18,254,197**	**100.0%**	**1,559,417,908**			
Medicaire Crossovers**	**$ 113,212,218**									
Total Elderly Recipients	**149,027**		**13,506**	**34,034**	**47,540**		**196,567**			
Expenditures Per Recipient*	**$ 10,342**		**$ 239**	**$ 441**	**$ 384**		**$ 7,933**			

* Service Expenditure/Recipient amounts do not contain adjustments, settlements or administrative costs.
** Medicare Crossovers are amounts that Medicaid bills Medicare for those Medicaid-eligible people who are also eligible for Medicare.
Source: SFY 2000 Program Expenditure Report and 2082 Report

Table 14
North Carolina Medicaid
State Fiscal Year 2000
Expenditures for the Disabled & Blind

Type of Service		Disabled	Percent of Service Dollars		Blind	Percent of Service Dollars		Total Blind & Disabled Dollars	SFY 2000 % of Total Dollars	SFY 1999 % of Total Dollars
Inpatient Hospital	$	326,859,313	16.4%	$	2,445,500	9.7%	$	329,304,814	16.3%	17.5%
Outpatient Hospital		113,552,563	5.7%		951,355	3.8%		114,503,918	5.7%	5.6%
Mental Hospital (> 65)		-	0.0%		(8,581)	0.0%		(8,581)	0.0%	0.0%
Psychiatric Hospital (< 21)		4,057,773	0.2%		2,638	0.0%		4,060,411	0.2%	0.2%
Physician		134,109,172	6.7%		1,185,587	4.7%		135,294,759	6.7%	6.8%
Clinics		140,018,774	7.0%		709,487	2.8%		140,728,261	7.0%	7.8%
Nursing Facility:										
Skilled Level		56,400,310	2.8%		1,265,457	5.0%		57,665,767	2.9%	3.2%
Intermediate Level		31,876,238	1.6%		1,362,946	5.4%		33,239,184	1.6%	1.7%
Intermediate Care Facility:										
(Mentally Retarded)		353,444,238	17.8%		6,765,399	26.7%		360,209,637	17.9%	20.2%
Dental		15,660,781	0.8%		113,251	0.4%		15,774,032	0.8%	0.8%
Prescription Drugs		359,524,944	18.1%		3,228,032	12.8%		362,752,975	18.0%	14.9%
Home Health		81,399,927	4.1%		1,065,056	4.2%		82,464,983	4.1%	3.9%
CAP/Disabled Adult		39,541,357	2.0%		1,368,543	5.4%		40,909,900	2.0%	2.0%
CAP/Mentally Retarded		174,476,063	8.8%		1,841,117	7.3%		176,317,180	8.7%	7.5%
CAP/Children		11,980,624	0.6%		-	0.0%		11,980,624	0.6%	0.6%
Personal Care		24,271,355	1.2%		1,124,325	4.4%		25,395,680	1.3%	1.2%
Hospice		5,164,068	0.3%		18,669	0.1%		5,182,737	0.3%	0.3%
EPSDT (Health Check)		1,096,275	0.1%		6,688	0.0%		1,102,963	0.1%	0.1%
Lab & X-ray		3,050,463	0.2%		33,783	0.1%		3,084,246	0.2%	0.2%
Adult Home Care		33,685,057	1.7%		274,069	1.1%		33,959,126	1.7%	1.6%
Other Services		28,544,439	1.4%		232,862	0.9%		28,777,301	1.4%	1.5%
Total Services	**$**	**1,938,713,734**	**97.4%**	**$**	**23,986,184**	**94.8%**	**$**	**1,962,699,918**		
Medicare, Part A Premiums		6,076	0.0%		609,176	2.4%		615,252	0.0%	0.0%
Medicare, Part B Premiums		36,666,148	1.8%		546,607	2.2%		37,212,755	1.8%	1.80%
HMO Premiums		15,804,976	0.8%		173,001	0.7%		15,977,977	0.8%	0.7%
Total Premiums	**$**	**52,477,200**	**2.6%**	**$**	**1,328,785**	**5.2%**	**$**	**53,805,984**		
Grand Total Services & Premiums	**$**	**1,991,190,933**		**$**	**25,314,969**		**$**	**2,016,505,902**		
Medicare Crossovers*	**$**	**70,152,844**		**$**	**935,897**		**$**	**71,088,741**		
Number of Disabled/Blind Recipients		**201,878**			**2,354**			**204,232**		
Service Expenditures Per Recipients**	**$**	**9,863**		**$**	**10,754**		**$**	**9,874**		

* Medicare Crossovers are amounts that are billed to Medicare for those Medicaid clients who are also eligible for Medicare.

** Service Expenditures Per Recipient does not include adjustments, settlements or administrative costs.

Source:SFY 2000 Program Expenditure Report and 2082 Report

Table 15
North Carolina Medicaid
State Fiscal Year 2000
Expenditures for Families and Children

Type of Service	AFDC Adults	% of Service Dollars	Special Pregnant Women	% of Service Dollars	AFDC Children & Other Children	% of Service Dollars	Indigent Children	% of Service Dollars	Total Families & Children Dollars	SFY 2000 % of Total Dollars	SFY 1999 % of Total Dollars
Inpatient Hospital	$ 86,936,029	31.5%	$ 78,558,813	39.5%	$ 56,890,918	21.3%	$ 149,495,735	31.8%	$ 371,881,495	30.7%	31.1%
Outpatient Hospital	44,491,002	16.1%	20,982,254	10.5%	23,271,583	8.7%	40,964,590	8.7%	129,709,429	10.7%	10.1%
Psychiatric Hospital (< 21)	309	0.0%	17,486	0.0%	6,212,219	2.3%	4,204,340	0.9%	10,434,355	0.9%	0.7%
Physician	51,889,218	18.8%	51,689,263	26.0%	42,276,433	15.8%	97,424,406	20.7%	243,279,320	20.1%	19.2%
Clinics	14,467,896	5.2%	23,729,119	11.9%	63,457,557	23.7%	52,966,645	11.3%	154,621,217	12.8%	12.4%
Nursing Facility:											
Skilled Level	47,059	0.0%	-	0.0%	22,268	0.0%	-	0.0%	69,327	0.0%	0.0%
Intermediate Level	795	0.0%	-	0.0%	79,337	0.0%	-	0.0%	80,132	0.0%	0.0%
Intermediate Care Facility:											
(Mentally Retarded)	31,592	0.0%	-	0.0%	2,662,769	1.0%	745,721	0.2%	3,440,082	0.3%	0.3%
Dental	8,385,023	3.0%	708,527	0.4%	8,979,778	3.4%	16,554,317	3.5%	34,627,645	2.9%	2.9%
Prescription Drugs	45,113,218	16.3%	6,074,294	3.1%	25,993,174	9.7%	44,730,647	9.5%	121,911,333	10.1%	8.8%
Home Health	3,651,202	1.3%	1,005,759	0.5%	3,342,330	1.2%	6,005,955	1.3%	14,005,246	1.2%	1.1%
CAP/Disabled Adult	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
CAP/Mentally Retarded	-	0.0%	-	0.0%	2,041,703	0.8%	-	0.0%	2,041,703	0.2%	0.0%
CAP/Children	-	0.0%	-	0.0%	349,689	0.1%	-	0.0%	349,689	0.0%	0.0%
Personal Care	339,337	0.1%	11,562	0.0%	68,197	0.0%	77,017	0.0%	496,113	0.0%	0.0%
Hospice	183,393	0.1%	-	0.0%	33,722	0.0%	48,248	0.0%	265,363	0.0%	0.0%
EPSDT (Health Check)	106	0.0%	31,217	0.0%	8,464,735	3.2%	24,972,530	5.3%	33,468,588	2.8%	2.7%
Lab & X-ray	2,419,243	0.9%	3,042,551	1.5%		0.0%	2,890,961	0.6%	8,352,755	0.7%	0.7%
Adult Home Care	3,005	0.0%	-	0.0%	5,277	0.0%	3,689	0.0%	11,971	0.0%	0.0%
Other Services	10,048,396	3.6%	8,912,892	4.5%	12,909,165	4.8%	13,989,034	3.0%	45,859,486	3.8%	7.2%
Total Services	**$ 268,006,822**	**97.0%**	**194,763,735**	**97.9%**	**258,453,203**	**96.6%**	**455,073,835**	**96.9%**	**1,176,297,596**	**97.0%**	**97.0%**
Medicare, Part A Premiums	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
Medicare, Part B Premiums	243,049	0.1%	12,132	0.0%	2,867	0.0%	6,416	0.0%	264,463	0.0%	0.0%
HMO Premiums	7,942,136	2.9%	4,265,894	2.1%	9,086,903	3.4%	14,473,814	3.1%	35,768,747	3.0%	2.8%
Total Premiums	**$ 8,185,185**		**4,278,025**		**9,089,770**		**14,480,229**		**36,033,209**		
Total Services & Premiums	**$ 276,192,007**		**199,041,760**		**267,542,973**		**469,554,064**		**1,212,330,805**		
Medicare Crossovers*	**$ 791,103**		**36,102**		**(8,198)**		**7,411**		**826,417**		
Number of Family & Child Recipients	**137,190**		**72,766**		**200,188**		**415,152**		**825,296**		
Service Expenditures Per Recipient**	**$ 2,013**		**$ 2,735**		**$ 1,336**		**$ 1,131**		**$ 1,469**		

* Medicare Crossovers are Medicare charges that are billed to Medicaid.
** Service Expenditures per Recipient does not include adjustments, settlements, or administrative costs.

Source: SFY 2000 Program Expenditure Report & 2082 Report

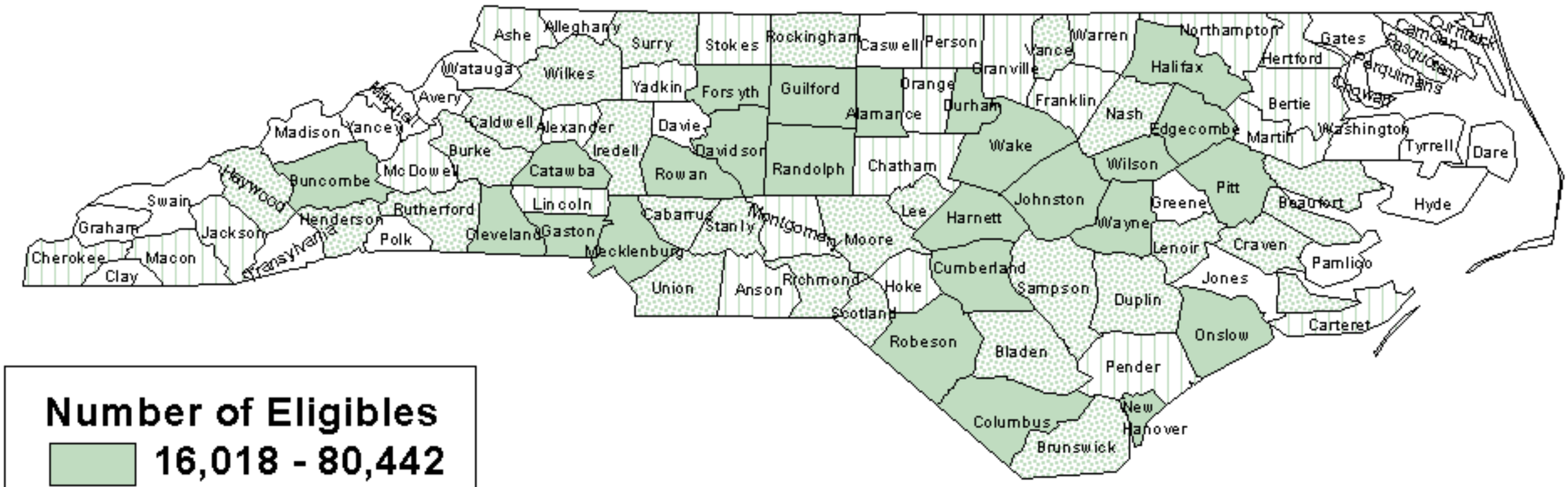
Table 16
North Carolina Medicaid
State Fiscal Year 2000
Medicaid Copayment Amounts

Service	Copayment Amount
Chiropractor visit	$1.00
Dental visit	$3.00
Optical service	$2.00
Optometrist visit	$2.00
Outpatient visit	$3.00
Physician visit	$3.00
Podiatrist visit	$1.00
Prescription drug (including refills)	$1.00

Appendix B

Medicaid MAPS

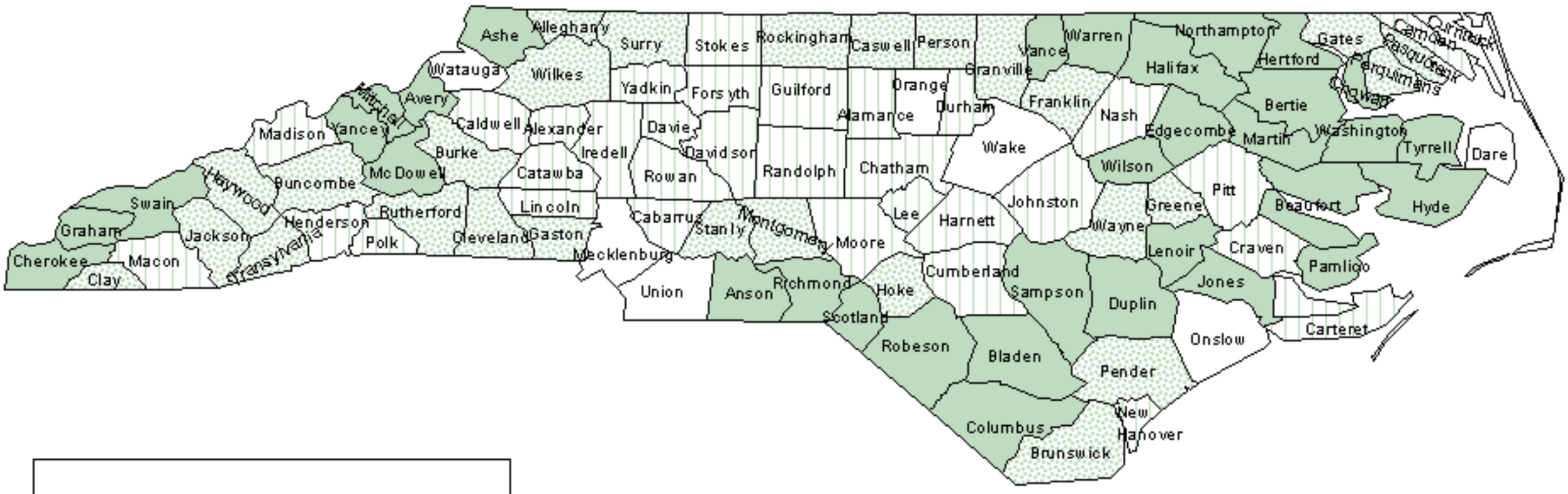
Medicaid Eligibles
SFY 2000



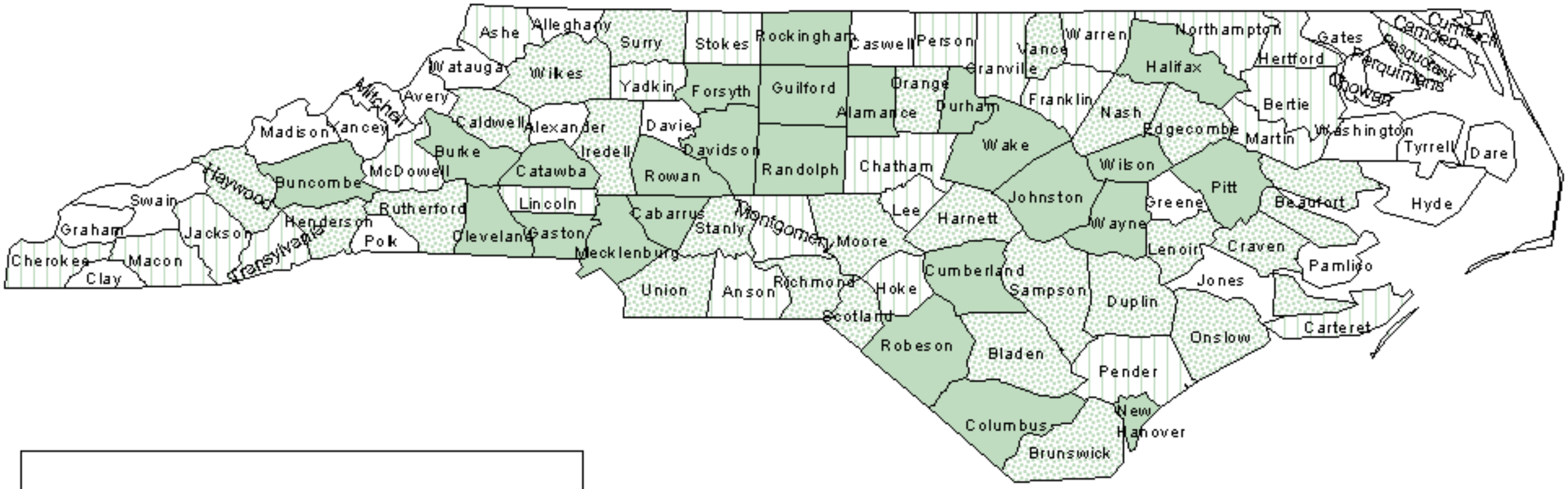
Number of Eligibles

- 16,018 - 80,442
- 8,442 - 15,764
- 4,423 - 8,284
- 918 - 4,211

Medicaid Expenditures Per Capita
SFY 2000



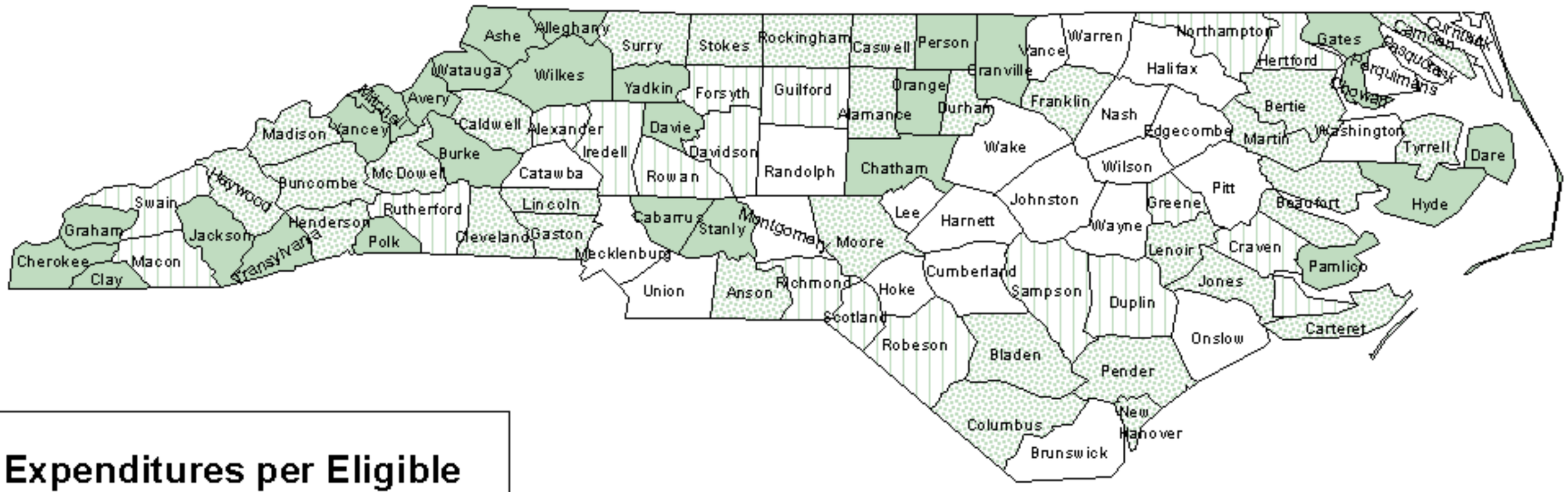
Medicaid Expenditures
SFY 2000



Expenditures

- $58.5M - $270.9M
- $36.1M - $57.50M
- $17.8M - $33.00M
- $3.7M - $17.500M

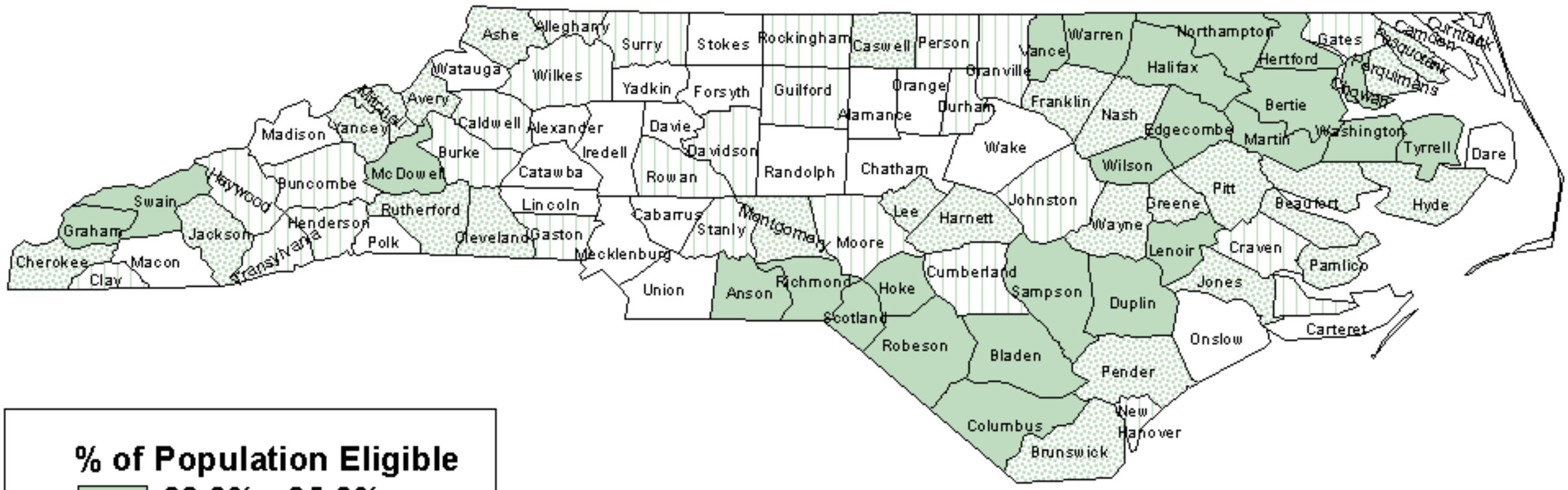
Medicaid Expenditures Per Eligible
SFY 2000



Expenditures per Eligible

- $4300 - $5700
- $4000 - $4300
- $3700 - $4000
- $3000 - $3600

Percentage of Population Eligible for Medicaid SFY 2000



% of Population Eligible

- 23.0% - 35.0%
- 17.3% - 22.7%
- 13.8% - 17.2%
- 7.5% - 13.7%